29 APRIL 2000

CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

DoH seeks low generic prices and no Cat D

Lord Hunt tells C&D how price cuts will affect pharmacists

Breaking the drug habit at Birdsgrove

Lloydspharmacy in health/wellbeing pilot

Practising pharmacy the Estonian way

Guest editor: Clive Jackson looks at the evolving NHS

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LEGAL CATEGORY: P

PRODUCT LICENCE NUMBER: Tablets 5221/0001.

MARKETED BY: UCB Pharma Limited, Watford, Herts, WD1 8UH.

For further information please contact: UCB Pharma Limited, UCB House, 3 George Str Watford, Herts, WD1 8UH.
Telephone (01923) 211811. Facsimile (01923) 229002.

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CHEMIST & DRUGGIST

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REGULARS

COMMENT

When every pharmacy contractor in England and Wales gets a letter from Lord Hunt, the health minister, you can bet there is bad news behind the sugared words. Contractors are about to be sandbagged as a consequence of the dust-up between the Government and the generics industry over pricing (p4). It is something pharmacists do not want and cannot afford. Suppliers are not going to supply drugs at a loss. They will adjust discounts and discontinue uneconomic lines. It costs about 20p to blister pack and carton a strip of 28 tablets. The 'new Tariff' price of a number of common drugs falls close to, or below that level, a consequence of taking average prices from the largely 'pre-OPD period' of November '98 to January '99. Abolition of category D comes as no surprise – the Government says it 'encourages speculation in the supply chain' – but it will not encourage pharmacists to source products in short supply which cost more than the Tariff reference price. They are more likely to ask GPs to prescribe a branded alternative or send patients to try elsewhere. The sad thing is that, according to one generic manufacturer, the £200m the Government claims it 'lost' as a result of last year's shortages and price rises is no more than it currently pays when the top 10 lines are prescribed as branded generics. The statutory scheme the Government proposes is not a solution to the last year's turbulence because the knock-on effects on pharmacists and patients have not been thought through. With the OXERA study still to report, the Government response is a premature over-reaction. As they stand the proposals will generate more product shortages as suppliers adjust to the new reference prices, and patients will suffer. And if the Government hopes, by coming up with such a sledgehammer for price control, that it will bounce what is a fragmented and diverse group of manufacturers and suppliers into a voluntary scheme, it is certainly living in Whitehall and not the real world.

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Miller Freeman

CPAC's vision for pharmacy

The Central Pharmaceutical Advisory Committee has suggested three models for the operation of community pharmacies in Northern Ireland.

The recommendations resulted from a project set up to help pharmacists and community representatives find ways of partnership working to improve local health services. The concept involves making best use of pharmacists' skills and position in the community to encourage people to use pharmacies as a source of information and healthcare advice.

'Building the community-pharmacy partnership' recommends three pharmacy adaptation models that can be tailored to individual local needs.

In the physical adaptation model the pharmacy would be re-oriented to supply ethical only products, discontinuing the sale of general merchandise. The emphasis would be on dispensing, advised self-care, medicines management and health promotion.

Partial physical adaptation would involve only part of the pharmacy being adapted for health promotion.

The extension of pharmaceutical services model would involve providing domiciliary pharmaceutical services to housebound patients and education on drug use and misuse to schools and community groups.

Government to cut generi

The Government is proposing to cut the price of generic medicines to the level of 15 months ago.

In order to stop the NHS being "ripped off", prices will be reduced to their average Drug Tariff level over the period November 1998 to January 1999. The Government claims this will correct the effect of last year's price rises which Lord Philip Hunt, health minister, called "impossible to defend".

After 15 months, prices of the top 200 generics remain 45 per cent above their previous levels, the Government says. The increase is expected to cost the NHS around £200 million.

At the same time, it is proposing to abolish Category D in the Drug Tariff because it has been "encouraging market speculation". Alternatives are to be discussed with the Pharmaceutical Services Negotiating Committee.

There will be separate discussions to cover arrangements in Scotland and Northern Ireland.

Chairman of Scottish Pharmaceutical General Council George Romanes was unsure how the changes would affect Scottish pharmacists. The SPGC is due to meet the Scottish Executive on May 3.

Reimbursement will not be a problem for community pharmacists, claims Lord Hunt. "We do not believe overall that community pharmacists will be affected," he said.

Under powers in the Health Act, the Government wants to introduce a statutory ceiling for generic prices across the UK. The maximum supply price will also be the Drug Tariff price, with discount clawback arrangements still applying. The scheme will be reviewed after 15 months.

Consultation on the scheme will last until May 24, with regulations laid in Parliament around the middle of June. There would then be an interval of four weeks from the date the regulations are laid before the maximum prices take effect which will "permit the supply chain to adjust" to the new price levels.

The fundamental review of the generic medicines supply chain being carried out by Oxford Economic Research Associates (OXERA) will continue and is expected to conclude in the summer. This will ensure that longer-term arrangements are put in place to deliver a fully competitive market, says the DoH.

The Government says it has considered introducing a voluntary scheme for setting maximum prices. Under the Health Act participants would be exempt from the statutory arrangements. But given the "fragmented and complex" nature of the market, it is doubts that an effective system could be negotiated.

The scheme will cover manufacturers and suppliers of generic medicines in primary care. Generics supplied to hospitals will not be covered, because tendering arrangements there are said to be working satisfactorily.

It will apply to all generics with an annual net ingredient cost of over £750,000 plus related preparations of the same molecule. It also applies to generics with an annual NIC of more than £100,000, but which have seen a material price increase since January 1999. Manufacturers contravening the scheme could face fines of up to £10,000 per day.

Estimated annual costs for implementing the scheme range from £1,000 for small manufacturers to £25,000 for companies with more than £25 million of NHS business.

Wally Dove, PSNC chairman, said the Committee will be working hard to ensure that contractors are not adversely affected by the Government's proposals. "In particular we will want to explore how it proposes – in the absence of Category D – to address the situation where there is a shortage of generic products," he said.

PSNC will also address the problems caused by de-stocking in the run-up to the new pricing system. It will respond in full to the consultation letter follow-

Lord Hunt's message to pharmacists

Lord Philip Hunt, health minister, explains to C&D how Government proposals to cut generic drugs' prices will affect pharmacists.

"Generic prescribing is one of the success stories of the NHS. Nearly two thirds of medicines are now prescribed generically and the money saved has enabled the NHS to invest in other areas of patient care – including new medicines.

"But, as community pharmacists know all too well, last year that success was undermined by steep price rises in many generics. And, whilst we kept being assured that any shortages resulting from the closure of one manufacturer had quickly been made good, pharmacists found that they had to spend far too much time tracking down supplies. I am grateful for the efforts which community pharmacists made to ensure that patients continued to get the medicines they needed.

"We also kept being assured that prices would soon come down. But, month after month, they went on going up. The cost to the NHS in England alone was around £200 million in 1999-2000 and, unless we did something, the cost this year would be higher still. We could not allow that to happen. And I'm sure most community pharmacists would agree with me on that.

"So we have now proposed a statutory price control scheme to take effect in June. This will put a cap on the prices which community pharmacists can be charged for the most commonly prescribed medicines – based on the average Drug Tariff prices between November 1998 and January 1999. Of course, I hope that there will continue to be competition below that price, and the existing arrangements for discount recovery will continue.

"Our experiences with generics last year showed us that the Category D arrangements have the potential to be abused. It is believed that movement of a preparation into Category D served as a signal to the supply chain to increase list price and hoard stocks. And, as we have seen, it can all too easily cause a backlog at the pricing bureaux, which is frustrating for everyone. We have already tightened up the rules, but have now proposed that Category D should be abolished.

"Although the number of products affected is relatively low compared to last year, community pharmacists will be concerned about the possible effects of this proposal. We are willing to consider alternative mechanisms and, with colleagues from Wales, we shall be discussing possibilities with the PSNC. There will be separate discussions in Scotland and Northern Ireland. However, the fact that it will be illegal to charge community pharmacists more than the statutory maximum price for generics will provide you with a good measure of protection.

"What I want to see for the future is a thriving and fully competitive generics market, not a price regulated market. So the proposal is that the price control scheme would be reviewed after 15 months. We are working on proposals for the longer term, which we will, of course, want to discuss in due course with community pharmacists' representatives. The fundamental review of the generics supply chain, which the department has commissioned from the Oxford Executive Research Association is likely to conclude by the summer and this will inform our discussions.

"We have made our proposals so that patients can benefit from the substantial additional resources we have made available to the NHS. We believe that they are fair and reasonable. And I hope community pharmacists will give them their support."

The health minister Lord Hunt at last month's PSNC dinner

rug prices

Table: examples of the proposed cuts

	Current Tariff price	Proposed new Tariff price
amoxycillin capsule 250mg, 28	**213**	99
aspirin dispersible 75mg, 28	**84**	7
beclamethasone inhaler 100mcg, 200 dose	**871**	824
bendrafluazide tabs 2.5mg, 28	**136**	14
cimetidine tabs 400mg, 60	**1612**	569
clotrimazole cream 1 per cent, 20g	**214**	132
diclofenac tabs 25mg, 84	**506**	262
frusemide tabs 20mg, 28	**118**	33
frusemide tabs 20mg, 250	**695**	437
thyroxine tabs 100mcg, 28	**162**	27
thyroxine tabs 100mcg, 1000	**6140**	958
propranolol tabs 40mg, 28	**117**	15
temazepam tabs 10mg, 28	**97**	96
phenobarbitone tabs 30mg, 28	**153**	13

ing a meeting with the DoH due to take place next Tuesday.

Department of Health comments about being "ripped off" do not stack up, according the British Generic Manufacturers Association. It points out that manufacturers have caught up with the shortages resulting from the closure of Regent Laboratories, and prices are now falling.

It is disappointed that the Government has chosen to act without waiting for the results of the OXERA review. The BGMA has been working with the DoH, OXERA, and the Office of Fair Trading, to find ways of introducing a more stable mechanism for supply and reimbursement.

One generic manufacturer has pointed out that the cost of blister packing and cartoning a tablet pack is around 20p. Several of the proposed reference prices are close to or below this figure, making the drug uneconomic to produce. Michael Watts, director of the British Association of Pharmaceutical Wholesalers, is concerned that a range of products will be uneconomic to produce and patients will suffer.

He believes pharmacists will lose out as a result of the abolition of Category D, if a generic product is not available, they will not be reimbursed for supplying a branded alternative.

The BAPW has been advocating change for the last 18 months, because "we are the victims rather than the perpetrators" of recent price increases. Mr Watts said anything that will stabilise the market must be a good thing.

But Lord Hunt should have waited until he had all the facts from the OXERA report before making the announcement. The OXERA panel is still on a learning curve, said Mr Watts.

Mr Watts accused shortline wholesalers of "profiteering", by buying up everything available and selling at inflated prices, but with a profit margin of only 1-2 per cent full-line wholesalers could not be so accused.

Full details of the proposed scheme and the new generic prices can be found at *www.doh.gov.uk/gendcon*.

The background

Generic prescribing rates in England have increased from 43 per cent in 1992 to 63 per cent in 1998. The Government is committed to encouraging increasing use of generics and has set targets to reflect this.

Over the past year there have been both apparent supply shortages and steep price rises in the generics market. These developments were attributed to the closure of Regent Laboratories for public health reasons, and to the introduction of patient packs.

After Regent's closure, the Government was informed that other manufacturers would make up the shortfall and prices would start to fall back. Prices rose during the whole of last year, and while they are now stable they are still around 45 per cent higher than 15 months ago.

Since the introduction of patient packs, significant price increases have affected products that are still sold in bulk or had been patient packed for some time, the Government claims. And price increases associated with patient packs have been larger than manufacturers had previously indicated.

The Government has failed to identify reasons for the recent behaviour of the generics market. It has seen no evidence of an increased cost base to explain the higher prices.

Price increases have affected primary care group's abilities to make crucial service developments, says the Government. And in Scotland the increases have obstructed the ability of local healthcare co-operatives to develop services.

The Government believes the generics industry is unable to correct the price increases, and so has taken its own action.

Plea for greater recognition

The iceberg of illness, of which the GP sees just the tip, would overwhelm the NHS if it were not for the support of healthcare professionals such as pharmacists, claimed the chairman of the Royal Pharmaceutical Society's Welsh Executive recently.

But no-one calculates how much pharmacists save the NHS, or employers in reducing time off sick, or simply in relieving anxiety, pain and discomfort, Colin Ranshaw told the Executive's annual dinner.

This highly skilled workforce could contribute so much more if its role in patient care were more overtly recognised, if IT links were improved and if patients were encouraged to use pharmacists more for specific needs.

At present no-one had responsibility for helping patients to use medicines efficiently, or evaluating their progress with a medicine or discussing problems. "Pharmacists operating a medicines management service are the right people to fill the gap," he said.

He told his audience, which included representatives of patient groups: "We need to identify together how pharmacists' unique skills and attributes can be made to work harder for patients." Pharmacies could provide more services for older people, for example, particularly those taking several medicines.

"Community pharmacists are arguably the most responsive to patients' preferences of any health care professional – if they're not, they go out of business," he said.

RPSiS strengthens lobbying campaign

The Royal Pharmaceutical Society in Scotland is upping its briefing campaign for Scottish politicians.

Briefing documents are being sent principally to MPs and MSPs and will cover public health and healthcare issues, information about pharmacists and pharmacy services and aspects of RPSGB policy.

The first briefing paper, issued this month, sets out statistics on the pharmacy service in Scotland and the range of illness in the local population that a typical pharmacy can expect to serve.

A second 'topical paper' looks at emergency contraception.

Among the points made in the first set of briefing papers are that:

- the 1,150 community pharmacies in Scotland see an estimated 600,000 people a day
- Scottish pharmacists dispensed 55 million items last year
- an uncomplicated abortion can cost the NHSiS between £300 to £400, whereas a course of emergency hormonal contraception costs about £1.50, net of professional fees
- some 51.9 per cent of the 813 pregnancies in 13-15 year olds in Scotland in 1998 were delivered at term.

Pre-registration exam guide published

The 'Pharmacy Pre-registration Handbook: a survival guide' is the latest title from the Pharmaceutical Press.

The book concentrates on preparing for the pre-registration exam but also includes advice and information about the pre-registration training year as well. It is cross-referenced to the Royal Pharmaceutical Society's 'Pre-registration training manual' and gives guidance on collecting and recording evidence to meet performance criteria, worked examples of calculations, sample examination questions and multiple choice questions.

The book (ISBN 0 85369 445 1) by Lindsay Taylor is priced £24.95 and is available from the Pharmaceutical Press, PO Box 151, Wallingford OX10 8QU. Tel: 01491 829272.

Ben Zatland (centre) has taken over from Kirit Patel as the new chairman of the National Pharmaceutical Association. At its meeting last week, the NPA Board elected Gerald Alexander (right) as vice-chairman and Peter Jenkins remains as treasurer. Mr Zatland has represented West London on the Board since 1995 and is chairman of the Middlesex Group of Local Pharmaceutical Committees. Mr Alexander, also on the Board since 1995, represents North and West London. He has been Enfield and Haringey Local Pharmaceutical Committee chairman since April

HA asks LPC for ideas on HImPs

A health authority is paying for its local pharmaceutical committee to present its ideas on how pharmacy can input into health improvement programmes.

Barking & Havering HA is paying for locum cover to allow the nine LPC members to attend the meeting with the pharmaceutical adviser and other HA officials all day on Friday, April 28. The LPC will present ideas on how pharmacy can help improve the HA's HImPs and will focus on three key areas: care of the elderly, substance misuse, and mental health.

"We will identify the opportunities for a pharmacist to make a contribution," LPC secretary Hemant Patel told *C&D*. "We are pleased to have been invited to have an input into these HImPs because from these will flow the commissioning intentions. The HA and social services are sitting down together as partners to develop new services, [which] we hope to influence."

Local pharmacists are pleased that the HA has made this gesture, added Mr Patel. A newsletter outlining the LPCs proposals was being sent to contractors this week.

- The London LPC Forum is gearing up to launch its pharmacy strategy for London later in May. The strategy has been drawn up by all the LPCs in London and will be sent to HA chief executives, social services and other groups.

Pharmacies rejected in 'supersurgery' bid

Lloydspharmacy has applied a second time for a contract to dispense from the 'supersurgery' at St Paul's, Cheltenham, and has been turned down. Other pharmacies have also had contract applications rejected.

Lloydspharmacy already has a non-contract pharmacy on-site and has seen an increasing demand for NHS prescriptions to be dispensed, the company says. Independent research among patients at the centre supported the application.

The centre has five practices, 27 GPs and many other health facilities. An earlier application from Lloydspharmacy for an NHS contract was approved by Gloucestershire Health Authority, then rejected by the Family Health Service Appeal Authority after existing pharmacies collected a 6,000 signature petition against the bid.

The present pharmacy offers diagnostic testing, including healthy heart checks, in line with the health village concept.

Lloydspharmacy intends to appeal against the decision.

NPA gives guarded welcome to group protocol proposals

The National Pharmaceutical Association has welcomed the proposals to implement the recommendations of the first Crown Report and to clarify the legal uncertainty associated with group protocols.

However, it is concerned that the proposed changes in legislation could run contrary to two of the Crown Report's recommendations. The first is that supply under group protocol should be the exception to the norm and should apply only in limited situations; and secondly, that pharmacists should continue to supply the vast majority of medicines.

Of particular significance was the proposal to amend legislation to allow wholesale supply to be made to a number of "medical businesses" which would be able to supply medicines under patient group directions. These primary care trusts, family planning clinics and walk-in centres, and widening medicines supply routes could impact on community pharmacies.

There could be a risk of patient group directions becoming a favoured route of supply, not in the interests of improved patient care but in the interests of cost, believes the NPA. The Board also raised the possible conflict of interest arising from a PCT having the ability to sign off patient group directions and, at the same time, having the responsibility for purchasing the supply of medicines.

The NPA's response also stressed that the routine supply of medicine under a group direction for use outside its licensed indications is not in the best interest of patient care and safety.

Competence and lifelong learning Responding to the RPSGB's consultation on professional competence and lifelong learning, the NPA warned that the objective should always be to ensure quality improvements rather than simply increased regulation. It sees difficulties in defining competence within the profession. And although it recognises that lifelong learning and CPD is essential to meeting new challenges, the Board feels that those pharmacists who decided not to take on new roles still remained competent in other areas of their work.

The Board supports the concept of a single register which would be split. 'Practising' pharmacists would be those providing services directly to patients or healthcare professionals. 'Non-practising' pharmacists would be those working in industry, academia, administration or in non-pharmacy related engagement who do not wish to provide services directly to the public or healthcare professionals.

The Board did not support the concept of registers of pharmacists qualified for specialised areas of practice, feeling such an approach would be divisive and elitist.

Date rape drugs The NPA is to make representations to the Home Office to have 'date rape' drugs, such as flunitrazepam (Rohypnol) and midazolam, rescheduled from Schedule 3 Controlled Drugs to Schedule 2 due to concerns over the misuse of short-acting benzodiazepines.

Home Office consultation The Board has welcomed Home Office proposals to extend the requirement for doctors to hold licences to prescribe any Controlled Drug for the treatment of drug addiction. Currently, this licensing requirement only applies to cocaine, diamorphine and dipipanone. However, the NPA says that the responsibility for checking such licensing arrangements should not fall to community pharmacists before dispensing a Controlled Drug, as access to a central register of 'licensed practitioners' could be difficult.

Modernisation Action Teams In a joint letter to the health secretary Alan Milburn, the NPA and PSNC have stated their concern at the omission of pharmacists from the new NHS Modernisation Action Teams, (*C&D* April 22, p4). The NPA will continue to press for pharmacy representation on the teams.

Warfarin monitoring service A community pharmacy-based warfarin monitoring service pack introduced by the NPA last year is being used in a number of bids to health authorities.

Healthy Living Centre workshops Almost half of those members who attended the HLC workshops organised by the NPA last year have since taken steps towards establishing a healthy living centre project. A report of the workshops, outlining the application process, is available from the NPA to members and LPC secretaries on request.

NHS Direct The Board was encouraged to see that one of the NHS Priorities 2000/01-2002/03 is to complete the roll-out of NHS Direct by the end of 2000 and ensure that opportunities are taken to integrate it with walk-in centres and primary care services, including pharmacy. It was also pleased to see that pharmacy was given equal prominence to GPs, casualty and the ambulance service in a new NHS Direct advertising campaign.

European issues The Pharmaceutical Group of the European Union has produced two policy papers – on advertising of medicines and patient information. The papers had been produced to provide evidence to a working group set up by the Commission's Pharmaceutical Committee to review advertising of and information about medicines, and to consider whether changes in legislation were needed at European level. (Copies of the papers are available on request, tel: 01727 858687.)

The PGEU has also produced a response to a draft opinion on 'The role of the European Union in promoting a pharmaceutical policy reflecting citizens' needs: improving care, boosting innovative research and reducing health spending'. This addresses issues such as free movement of pharmaceuticals, containment of healthcare costs, pharmacists' reimbursement, widening the distribution of non-prescription medicines, pharmacists' remuneration and scrutiny of the existing medicines distribution chain.

Folic acid A new pack for pharmacists, promoting folic acid use in women planning pregnancy, developed by the NPA, the Health Education Authority, the Pharmacy Healthcare Scheme and Lanes, is available free of charge from the PHS.

Domiciliary oxygen service A joint response will be sent from the NPA and PSNC to the DoH's review of the domiciliary oxygen service in England.

Medication Management John Dixon, project manager for the medication management report, a joint venture between PSNC, NPA, RPSGB and CCA, said that research teams were being short-listed, and the project team was now waiting to hear whether the bid for DoH funding was successful.

St John's Wort labels agreed

Health food manufacturers and the Medicines Control Agency have agreed on the drug interaction warning that should appear on St John's Wort preparations.

Permanent labels should state 'Before taking this product: Please check with your doctor or pharmacist if you are taking any prescribed medicines as St John's Wort may affect the way they work.' The manufacturers recently took steps to overprint labels until a final wording was agreed.

The carton/sleeve and container should all carry the warning, as soon as is feasible.

The information sheet should still be available at point of sale.

Xrayser

Topical Reflections

Complaints about industry links with patient groups

The Medicines Control Agency is looking into drug company connections with web sites, after campaigns to make beta-interferon more widely available were found to be industry linked.

The Multiple Sclerosis Society complained that web sites funded by Biogen and Schering Healthcare implied that patient groups were campaigning independently for beta-interferon to be made available to all MS sufferers, whereas the campaigns were run by the companies.

The MCA forced Biogen to withdraw its 'Action for access' campaign as it breached the rules banning advertising of prescription medicines to the public. Schering Healthcare has withdrawn its MS Voice web site. Both companies argued that the campaigns were designed to enable patients to take part in the debate about making beta-interferon available throughout the NHS.

David Hinchliffe, Commons Health Select Committee, said it would question the National Institute for Clinical Excellence about links between drug companies and patient groups.

Fine for supplying

A pharmacist has been fined £300 for handing out three days' supply of methadone when the prescription was for daily dispensing.

Graeme Robertson admitted that in November 1998 he had supplied the Controlled Drug at Lloydspharmacy, Wellgate Centre, Dundee, not in accordance with the prescription and contrary to the Misuse of Drugs Act. Sheriff Ian Dunbar heard last month that the GP had prescribed 14 days' supply, with instructions that it was to be dispensed daily. Mr Robertson's solicitor said his client's and family's safety had been threatened by a 'resourceful individual' if he did not provide more.

Passing sentence, Sheriff Dunbar said the only solution in such circumstances was to contact the police immediately. Mr Robertson was dismissed from Lloydspharmacy in December 1998.

RPSGB brushes up your business

The Royal Pharmaceutical Society's information centre has published a bibliography on 'Business management in community pharmacy'.

The centre's seventh title in its series provides a listing of journal references on subjects ranging from buying a pharmacy through fitting it out, to security issues, stock control and legal aspects.

Bibliographies cost £7.50 to members or £15 to non-members.

Why doesn't anyone ask me what I think?

It seems to be a function of Government to change things, regardless of need, because that is what politicians think they are elected to do. The net result is a constantly changing regulatory framework within which we work.

This would not be so bad if I were consulted about those changes which could affect me. However, in all my years of working in community pharmacy it is ironic that the only government-initiated consultation exercise in which I was actively invited to participate – on producing a community pharmacy strategy – resulted in a lot of hype but absolutely no action.

But that does not mean to say that change does not occur. It does, and in the case of this Labour Government it is changing uncomfortably fast. In one short week *C&D* reported that the Autumn Strategy is now yesterday's news and is replaced by a NHS wide strategy co-ordinated through new health action teams (with no pharmacist members); that Government NHS modernisation teams are still looking at smart cards; that a pilot scheme is to look at multi-disciplinary sharing of on-line health records; and that proposals for group protocols (in MLX260) could have potentially explosive consequences for pharmacists.

These are all initiatives that could seriously affect my future practice but I have not been directly asked about any of them. To be fair, both the Pharmaceutical Services Negotiating Committee and the National Pharmaceutical Association have voiced their dismay at the lack of pharmacists on the health action teams and concern about the MLX 260 proposals but this is not the same as direct consultation.

Part of the problem may be my own fault in that I probably do my job too well, with few public complaints and even less praise, but I am still being ignored and decisions are taken on my behalf which directly affect my livelihood. I do not care whether the invitation comes from the PSNC, the NPA or even the Department of Health. But I would like to be consulted!

How do I vote, and who do I vote for?

I have just spent a long time reading the answers to the three questions posed by *C&D* (last week) to candidates in the forthcoming Royal Pharmaceutical Council election. I have also read their official 'Statements of Policy' and the preliminary consultation paper from the RPSGB on the composition of the Council and election of Council members.

So how do I vote, who do I vote for and on what basis do I vote? How I vote has already been pre-ordained as the single transferable vote, a system I am broadly in favour of retaining, but who I vote for is more difficult as statements or written answers to standardised questions are a poor substitute for interactive debate.

However, I am not in favour of the poorly attended, single centre hustings conducted by the Young Pharmacists Group because the debate must be freely available to all candidates and the whole electorate.

An alternative could be the production and distribution to all members with the voting papers of the video of an independently controlled, audience participation debate involving all candidates, similar to the BBC's 'Question Time'. This, though, would be a costly exercise.

For the future, a live interactive internet video conference will soon be technologically feasible.

On what basis I cast my vote will depend on the structure of Council. Under the present simple system of 21 elected members my preferences will endeavour to elect members who reflect my own priorities. However this system is also a lottery of representation with sheer chance determining whether any Council member is personally known to me or lives in my area.

At the risk of complicating the composition of Council I would like to see a move to regional representation with members responsible to a constituent electorate.

So this year I will cast my vote as best I am able under the present rules but I will also, and more importantly, reply to the Society's consultative document. The questions asked are sufficiently open-ended that all opinions can be expressed.

Abstaining in the Council elections might be considered a justified protest but a reasoned reply to the Society's second consultation paper must be an essential requirement for all pharmacists

ABPI campaigns for drug information for patients

The Association of the British Pharmaceutical Industry is launching the final stage of its campaign to lift European restrictions that prevent pharmaceutical companies providing factual information direct to patients.

Patients should have the right to information on Prescription Only Medicines provided by British pharmaceutical companies through the internet and other media, said Professor Trevor Jones, ABPI director general. Many are already accessing US web sites where information provided by drug companies and direct-to patient advertising is legal.

"As the patient demand for information grows it is becoming clearer that the current restrictions which prevent the industry from informing patients about medicines often do not work in the best interest of patients," said Professor Jones, at a Pharmaceutical Marketing Society meeting on March 30.

Regulatory controls in the UK prevent pharmaceutical companies disseminating information about products on the internet. But non-pharmaceutical organisations can set up a web site giving information about any medicine.

The spread of information on the internet – some of it unreliable – means that "the genie is out of the bottle", said Professor Jones. He called for "responsible and fact-based" information to be provided direct to patients.

The first stage of aligning the industry with the ABPI's Informed Patient initiative, which began in 1998, is almost complete. Phase two involves seeking alliances with patient groups, the British Medical Association, Royal Colleges and others. This aims to neutralise concerns by communicating the stepwise strategy.

Doctors, however, do not want informed patients. A third are opposed to patients being informed and another third "don't know". The BMA has told the ABPI that it is concerned about the wider impact this will have on doctor's practice.

Pharmacists should be on pain teams

Pharmacists should be included in multidisciplinary chronic pain teams, a report has suggested.

Community pharmacists have a role in enabling access to the specialist and controlled medicines used in palliative care, and in providing education and training on the pharmacological management of pain. But there are no specific courses for pharmacists interested in pain management, says the report on 'Services for patients with pain'.

The report is one of four just published by the former Clinical Standards Advisory Group, set up in 1990 to advise health ministers on standards of clinical care. It was abolished last year under the Health Act 1999, which set up the Commission for Health Improvement to carry out similar reviews of clinical services.

A report on 'Services for patients with depression' warns that prescribing costs would increase greatly if all patients treated with tricyclic antidepressants were switched to selective serotonin re-uptake inhibitors, although the picture may change as SSRI patents expire.

The usual dose of tricyclics in primary care, 50mg, is well below the level recommended in expert guidelines, the report says.

Although many patients are probably being under-treated, few antidepressants have been tested in representative samples of patients in primary care and many GPs see improvements in patients on low doses.

A recent meta-analysis found that, although low doses were less effective than higher doses, they were more effective than placebos and caused fewer adverse events such as side effects and non-compliance.

Whichever class of antidepressant is chosen, the effective dose should be continued for four to six months after recovery from a first episode, the CSAG recommends. If there is a history of recurrence, treatment should continue for five years.

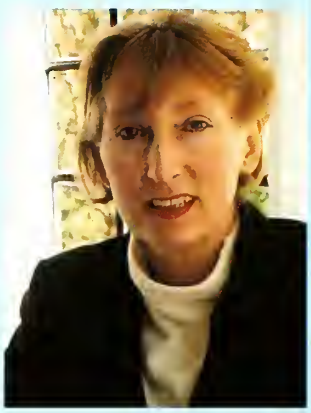
The report suggests that four symptoms of depression lasting more than two weeks is a useful rule to identify those who will respond to a tricyclic (over 100mg) better than a placebo. Antidepressants should certainly be given to those with recurrent episodes of depression or psychotic symptoms.

The other reports covered services for outpatients and patients with epilepsy. Health minister Lord Hunt said last week the Government was determined to eradicate the unacceptable variations in services identified in the reports.

LAMBETH OUTLOOK

Challenging times

Beverley Parkin, director of public affairs at the Royal Pharmaceutical Society, outlines how it is meeting the Prime Minister's recent 'challenge' to the professions



Beverley Parkin

In the 1997 White Paper, 'The new NHS: Modern, Dependable', Tony Blair wrote: "This is the beginning of a process of modernisation." As many commentators noted, the process was soon snagged on a variety of thorny points, including waiting lists, winter crises and and the debate over NHS rationing, linked to new products such as Viagra and Relenza.

Both the last Government and this one have had a crack at 'ineffective' NHS bureaucracy but previously this has concentrated on NHS structure, rather than performance. Recently, though, the Government has thrown down the gauntlets of clinical standards and structural modernisation, challenging "the forces of conservatism" across the NHS. For the first time in 1999 the health professions came under prolonged scrutiny and are now fully in the frame for reform.

But a bad flu outbreak last winter fuelled a growing perception that, without more money, the problems of delivering a modern and dependable National Health Service could not be resolved. An extra £1.5 billion allocated to health in the first two years of the Labour Government had already been swallowed up.

Last month, Gordon Brown's Budget promised an additional £2 billion each year for the next four years – an annual rise of more than 6 per cent above inflation. This time, however, the Government appears determined to see genuine, measurable improvements in standards and performance and it is prepared to force the pace of change as never before.

The Prime Minister has announced five new 'challenges' for the NHS, covering aspects of professional performance, patient care and public health. Ministers will drive forward a 'step change' in NHS reform, with a four-year action plan for modernisation to be published in July.

The Royal Pharmaceutical Society has responded positively to the call for modernisation, although it recognises that there are potential challenges for the profession in certain of the flagged developments. It has highlighted to Government where its own current policy work has identified the need for change within the NHS, suggesting to the Government that it looks at its five challenges alongside another, underpinning objective for the NHS. This is to modernise the use of medicines by better managing the choice, deployment and benefits of and access to what is the UK's most common healthcare intervention.

The Prime Minister has also pointedly challenged the professions to modernise their ways of working and pharmacists are keen to enhance their services to patients by working more closely within NHS teams. One key development would be for pharmacists to take greater responsibility for managing repeat medication.

Opening a new NHS walk-in centre in Peterborough on April 13, Mr Blair signalled that he sees a role for pharmacists in handling repeat medication. The profession must now move swiftly to build on this welcome opportunity.

Managing repeat medication was a key plank in the Society's 'Building the Future' strategy and many continue to see it as a gateway to a more integrated NHS medicines management role – and eventually an independent prescribing role for the profession.

With some 70 per cent of prescriptions being issued as repeats, there would clearly be considerable impact on patient well-being if pharmacists were managing the process, providing monitoring, assessment and support. Properly structured, this would also begin to allow for the development of the 'patient concordance' approach, with quality interventions, advice and options for referral available to patients.

PROFIT *Naturally*

The No.1 Pharmacy Constipation Remedy

Views from candidates at The Young Pharmacists' Group hustings

Candidates answer questions from the floor

During the Young Pharmacists' Group hustings, five candidates for election to the Pharmaceutical Society's Council were given the opportunity to express their views and answer questions from the audience.

Steven Curtis, Dr Brian Curwain, Dr Nicola Gray, Kirit Patel and Alaster Rutherford (pictured above left to right) answered questions on subjects including emergency hormonal contraception, the Society's Public Affairs Directorate, and threats to the profession.

The discussion took place at the joint YPG and Institute of Pharmacy Management International conference in Birmingham on April 16.

Mr Curtis said that communication was an important issue for Council to consider. It needs to be more transparent and members interest in it needs to be stimulated. "We need an open and honest Council and one that communicates and communicates effectively," he said.

Dr Curwain said that Council should be more outward looking and flexible. Workforce lessons include adapting pharmacy to new conditions and technologies, addressing the issue of pharmacist and student numbers, and understanding opportunities offered by the new NHS. Pharmacy needs to raise its profile with opinion formers and the public, said Dr Curwain.

Dr Gray said that membership services and the branch system must be improved. The skill mix within sectors, the profession, and healthcare as a whole needs to be considered. Council should use its PR machine more effectively, said Dr Gray.

Kirit Patel's three main points were pharmacist prescribing, recognition and adequate remuneration. He thinks the profession has been sidelined on the prescribing issue. Mr Patel is against a P licence for emergency hormonal contraception. He called pharmacists' remuneration "pathetic".

Alaster Rutherford's themes were those of glasnost, perestroika and revolution. "I'm for a lot more freedom and truth," he said. Council meetings should be open to all, with agendas and minutes available on the internet. The standard of communication between Council and members is not good enough, he said.

On the subject of emergency hormonal contraception, Dr Gray said that supply should be under group protocol. The practice of history taking and record keeping could provide a template for other services. And the fact that the system is not sales-driven is an added advantage, she said.

Dr Gray believes that the Society's Council is "hedging their bets" on the method of supply. If EHC gets a P licence, the profession should not be left on the sidelines, she said.

Mr Patel said that EHC should be available free of charge. He warned that an over-the-counter version would cost about £12. Pharmacists should hold out for prescribing rights.

"The only way we will get prescribing rights is if we can convince the Government that it will save money," he said.

Dr Curwain is in favour of OTC supply. Mr Rutherford predicts the Medicines Control Agency will grant a P licence.

Mr Curtis also thinks that pharmacists should hold out for prescribing rights. "It's an issue we have to force," he said. If the profession goes down the group protocols route, pharmacists may end up practising completely under group protocols, he warned.

Student issues

The 58th annual conference of the British Pharmaceutical Students' Association took place last week

One of the major topics of discussion at the British Pharmaceutical Students' Association's conference was the Runcorn 'Peppermint water' case.

The conference voted overwhelmingly that the Royal Pharmaceutical Society's response to the incident had been worrying.

Proposing the motion, Robert Forde, ex-Aston, said: "This incident raised many questions about degree courses, assessment and training. The Society had ample time to prepare a positive response, however it chose to make derogatory comments towards students' knowledge of modern extemporaneous dispensing."

Later in the conference, the Society's director of professional standards, Susan Sharpe, addressed the students about the Runcorn case and other issues.

An open forum debate centred on the forthcoming Branch Representatives' Meeting and the BPSA's request for office space at the Society's headquarters in Lambeth.

Outlining the reasons for the request, BPSA president Jonathan Burton explained that the Association had come to a turning point. "BPSA will have great difficulty in furthering its professional and educational offerings without this support," he said.

Delegates agreed the move would benefit both the BPSA, with room for archiving information and holding meetings, and the Society, by allowing weekly contact with the student body. It was pointed out that the Scottish and Welsh Executives have their own facilities. As a national branch the BPSA feels it could improve on its current service to members with this type of support.

Conference voted unanimously in favour of supporting emergency hormonal contraception supply to be made under group protocols through community pharmacies.

New executive

Noel Wicks has succeeded Jonathan Burton as president of the BPSA. Emily Horwill is the new vice-president, Catherine Walker is treasurer and Gavin Miller, secretary general.

Katherine Whitehead (right) received the Johnson & Johnson MSD 'Patient Counselling Competition' award from Stella Buchan

Pictured are finalists in the Reckitt & Colman Pharmacy Student of the Year award, won by Scott Dalgleish of Strathclyde School of Pharmacy (centre right) and presented by Mel Smith, R&C's professional relations manager. Other finalists are (from left) Deborah Jacob, Anna Watson, Alex Adam, Emma Smith and Rupinder Flora. The prize will allow Scott to represent the BPSA at this year's IPSF Congress in El Salvador

THINK IBUPROFEN

No.1

THINK CUPROFEN

Cuprofen, still the No.1 recommended analgesic brand[1] and <u>still</u> only available in pharmacy.

Thanks to your recommendation, the best selling success of Cuprofen in pharmacy continues.[2] Cuprofen offers the premium brand quality, performance and value for money price your customers like - and the profits you want. And as Cuprofen remains loyal to pharmacies, your customers will remain loyal to you.

So when you think ibuprofen,
think Cuprofen.

SSL International plc

Further information is available from SSL International plc, Tubiton House, Oldham OL1 3HS. Telephone: 0161 652 2222.
Cuprofen is a Trade Mark of Seton.

[1]Taylor Nelson Sofres Counterpoint MAT Quarter 4 1999
[2]Cuprofen is the best selling 400mg brand - Independent Pharmacy Audit MAT Jan 2000

Cuprofen
IBUPROFEN TABLETS

Senokot
The natural solution

In the second of our series, Senokot, the Number 1 recommended brand for sufferers of occasional constipation, introduced the Diet Modifiers – consumers who try and manage their constipation through changing their diet (*C&D* last week).

Here, in part three, we look at the how you can advise and safely recommend Senokot to Diet Modifiers for the treatment of occasional constipation.

The pharmacist's role

Sufferers often see the subject of constipation as too embarrassing to discuss, and they tend to try and cope without any help at all. However, you are a logical source of information and advice for them and, as the forthcoming Senokot campaign will be encouraging Diet Modifiers to approach their pharmacist, it is important for you to be prepared.

BSIP Laurent/Science Photo Library

Bloating and pain can be symptoms of constipation

A typical example

Mrs DM has been suffering from constipation for the last three days and is feeling very bloated and full, with occasional bouts of cramping pain. She normally has a regular, daily bowel pattern but has suffered from occasional periods of constipation in the past, usually when she is stressed at work and, as a result, not eating properly.

Previously she has always tried to treat her constipation through changing her dietary habits, as she prefers the natural approach to treating any condition. Mrs DM is wary of laxatives because she believes that they will cause her to have an 'accident'.

This time, however, she has approached her pharmacist to find a natural treatment that works within 12 hours as she has seen a TV advertisement for a natural product that works overnight to relieve constipation. She also has an important event the following evening and feels that the changes in her diet will not solve the problem quickly enough.

When questioned by the pharmacist, Mrs DM admits that in the past her constipation has taken up to a week to treat using her diet modification method and that she has felt very uncomfortable and frustrated with it. She is, however, insistent that she wants a natural, gentle product that works quickly, although not immediately, and that is easy and convenient to take.

Senokot's solution

Senokot is made with 100 per cent standardised natural senna, which means that it works in harmony with the body to treat occasional constipation. Two tablets taken at night will typically work in 8 to 12 hours by gently stimulating the bowel, ensuring effective, predictable relief from constipation the following morning.

Mrs DM was very happy with the recommendation of Senokot from the pharmacist and was only sorry that she didn't realise the effectiveness and naturalness of the product before as she felt it would have saved her a lot of unnecessary suffering.

So, you can be confident that in recommending Senokot to your customers, you are providing them with the natural choice for treating constipation.

Next week: We take a look at how you can cater for constipation sufferers in your pharmacy.

Senokot®

Contains natural Senna

Senokot and the sword and circle symbol are trademarks.

Senokot Essential Information ***Active Ingredients***: Each Tablet contains standardised senna equivalent to 7.5mg total sennosides. Each 5ml spoonful of Syrup contains standardised senna extract equivalent to 7.5mg total sennosides and 3.3g of sugar. Each 5ml (2.73g) spoonful of chocolate Granules contains standardised senna equivalent to 15mg total sennosides and 1.64g of sugar. ***Indications***: Relief of occasional or non-persistent constipation. ***Dosage Instructions***: Adults and children over 12: Two Tablets in 24 hours, or two 5ml spoonfuls of Syrup, or a level 5ml spoonful of Granules, taken at night. Children 6-12: One 5ml spoonful of Syrup taken in the morning. Tablets and Granules to be taken only on a doctor's advice. Children under 6: Syrup to be taken only on a doctor's advice. Tablets and Granules not recommended ***Contraindications***: In common with other laxatives Senokot should not be given when undiagnosed acute or persistent abdominal pain is present. ***Precautions and Warnings***: If there is no bowel movement after three days consult a doctor. If laxatives are needed every day or abdominal pain persists consult a doctor. Do not take Senokot Syrup or Granules if you are a diabetic. ***Side Effects***: Temporary mild griping may occur during change in dosage. ***Retail Sale Price***: Tablets: 6 Tablets – £1.29, 20 Tablets – £1.89, 60 Tablets – £4.34, 100 Tablets – £5.19. Syrup: 100ml – £3.05. Granules: 100g – £4.49. ***Marketing Authorisations***: Senokot Tablets – 0063/5000R, Senokot Syrup – 0063/ 5003R and Senokot Granules – 0063/5002R. ***Supply Classification***: Through registered pharmacies except 6's tablet pack (GSL). ***Holder of Marketing Authorisations***: Reckitt & Colman Products Limited, Dansom Lane, Hull, HU8 7DS. ***Date of Preparation***: April 2000

Counterpoints

Herbal platform for new Clairol hair colour

Bristol-Myers is launching a new permanent hair colorant range under its Clairol Herbal Essences brand.

Herbal Essences Permanent Haircolour is designed to provide vibrant, long lasting colour enhanced by natural herbs and botanicals.

The range comprises 24 colours including two high lift blonde shades. The blonde shades are enriched with camomile, the reds with rosehip and the browns contain nutmeg.

The product is formulated to leave the hair smelling of the same fruity fragrance as in the Herbal Essences shampoos and conditioners.

The pack includes a rich after-colour conditioning treatment to help leave the hair soft and shiny.

The packs are flashed with a 'vibrant colour promise' to refund the purchase price to customers if they are not satisfied with the results. This offer will end on October 1.

Retail price is £6.49.

Bristol-Myers Co Ltd.
Tel: 01895 628000.

Oxygen breathes new life into Impulse

Elida Fabergé is relaunching its Impulse female bodyspray range and adding a new Oxygen sub platform on May 1.

The eight existing Impulse variants will come in new packaging designed to communicate the brand repositioning of all over body freshness.

New spray technology has been developed to provide an invigorating cool skin sensation on application.

Gina McKenzie, category trade manager for Impulse, says: "The relaunch is designed to differentiate female bodysprays from fine fragrances and deodorants to give potential users a core reason to believe in daytime freshness.

"Not only is there a big penetration opportunity but also added incremental business due to cross usage of female bodysprays and deodorants."

- A new Oxygen sub platform for the brand is also being introduced. The two new Impulse Oxygen variants are SCI - an invigorating, uplifting fragrance - and Air which is formulated to gently exhilarate the body.

Packaging for the new Oxygen products features a co-ordinated theme design of blue, silver and white with oxygen bubble graphics.

In research trials, the light and fresh Oxygen concept appealed to lapsed and non-users (19-24 years) with benefits transferred to the core range.

The relaunch will be supported by a £7 million campaign that includes TV, press and poster advertising, direct marketing initiatives, mass fragrance sampling and PoS material.

Retail price is £2.19 for 75ml.

Elida Fabergé.
Tel: 020 8481 6000.

New look for the Bach Flower Remedies available in July

New packaging for Bach Flower Remedies, distributed by A Nelson, is being introduced in July, and a new merchandising system will be made available for retailers.

To encourage new users, the existing 38 remedies will come in new livery which clearly displays the Bach signature. An improved merchandising system will allow for double facings of the ten most popular remedies as well as more space for the fastest selling product - Rescue Remedy.

Customers will also be able to buy mixing bottles, and a new range of leaflets will cover subjects such as coping with illness and the use of the remedies with animals.

A Nelson & Co.
Tel: 020 8780 4200.

Natural way to grab male love handles

Medestea is launching a new natural oral supplement targeting the male health and grooming market.

Adipos Forte for Men has been developed as a treatment for men who want to lose excess abdominal fat.

The supplement contains a natural mixture called adipovascolen, which is claimed to tackle the adipos connective tissue that is composed chiefly of fat cells. In men, the adipose tissues can be seen as bulges above the hips and in the abdominal cavity.

The product claims to increase the body's metabolic rate and microcirculation, reduce tissue swelling and improve the lymphatic system.

Retail price is £29.95 for 40 capsules

Medestea Ltd.
Tel: 020 7436 0033.

Aloe gives fresh appeal to Vaseline Intensive Care

Elida Faberge is launching a new aloe variant that spans both its Vaseline Intensive Care's skin and deodorant ranges.

Aloe Fresh is being introduced in body lotion and deodorant formats. It is designed to create a younger, more contemporary image across the brand and it is expected to be bought by younger consumers.

Vaseline Intensive Care Aloe Fresh Body Lotion with aloe vera and cucumber is a revitalising all over body lotion to soothe, refresh and help rehydrate skin. It is easily absorbed, non-greasy and has a clean, refreshing fragrance.

The lotion's cool fragrance and soothing properties make it suitable for after sun application. Retail prices are £4.35 for 400ml and £2.79 for 200ml. The body lotion will be available from May 22.

Vaseline Intensive Care Aloe Fresh Deodorant contains aloe plus pro-derma - a blend of ingredients that helps protect the underarm skin and make it less prone to irritation.

The new deodorant variant comes in an anti-perspirant aerosol, cream and roll-on. Retail prices are £1.99 for aerosol (150ml), £2.29 for cream (50ml) and £1.39 for roll-on (50ml).

The launch will benefit from a £3.5 million support programme for the brand and a £1 million sampling campaign. The TV and press advertising campaign will continue to focus on 'healthy feeling skin'.

Elida Fabergé.
Tel: 020 8481 6000.

A Sure way for both sexes to stay dry

Elida Faberge is launching new variants for both sexes in its Sure deodorant range.

Sure Oxygen is an invigorating new fragrance for women. It has a fresh yet feminine scent with clean top notes of hyacinth, fruity middle notes of green apple and woody base notes of cedar and sandalwood.

Retail prices are £2.19 for Anti-Perspirant Aerosol (200ml), £1.39 for Big Ball Roll-on (50ml), £2.39 for Ultra Dry Cream (50ml) and £1.99 for Invisible Stick (40ml).

ATV campaign aimed at women will support the launch, together with press advertising in women's magazines and a poster campaign.

Sure Cobalt for Men is a new male fragrance that contains a micro mineral formulation to deliver confidence and reassurance. It has citrus top notes of bergamot, with middle notes of black tea and base notes of cedar wood and musk.

Sure Cobalt is currently only available in an aerosol applicator. Retail price is £2.19 (200ml).

An advertising campaign for Sure Cobalt will be specifically targeted to men and will include a new male themed TV commercial, press advertising in men's media plus a poster campaign

A total of £20 million will be spent on the support campaign for the entire Sure brand this year.

Elida Fabergé.
Tel: 020 8481 6000.

Centrum ad campaign goes national

Whitehall Laboratories is unveiling a national campaign for its Centrum range after advertising in the London area produced a claimed sales increase of 41 per cent.

Full page adverts targeting both men and women are set to appear in monthly titles ranging from *GQ* and *FHM* to *Red*, *Cosmopolitan*, *Prima* and *M&S* magazine until July.

Strip ads with sporting catchlines are planned to appear in the weekly and Sunday editions of *The Times* and the *Telegraph* sports pages around major golf, football and tennis events.

The press campaign is intended to prompt low, or non-users of vitamin and mineral supplements to think about whether they are addressing all their nutritional needs.

Centrum will also be back on air with a three week television campaign in the London and Midlands ITV regions from the end of May until mid-June.

Whitehall Laboratories.
Tel: 01628 669011.

Mosi-guard roadshows underway

Mosi-guard Natural is being promoted at various exhibitions and shows around the country during the summer, and can be seen at Chemex 2000 in September.

Monty the Mosquito and the ultimate millennium bug – a VW Beetle – will feature in the roadshow, supporting an on-pack promotion underway in pharmacy stockists. Consumers have the chance to win the car and can also win Compaq computers as well as being able to send off for Monty the Mosquito, a buzzing bug toy.

The promotion is being run to the end of the year. Mosi-guard Natural is the only insect repellant on the market recommended for babies from three months old.

Mosi-guard International Ltd.
Tel: 0113 238 7502.

Twelve shots free with Kodak Ultra

An added value promotion from Kodak this summer offers retailers a chance to drive sales of single use cameras during a key period.

From June through the summer via selected channels, promotional packs of Kodak Ultra and Ultra Super Flash cameras will offer 12 shots free.

The £60 million at retail single use camera market has grown by 62per cent since 1997, but only 20 per cent in the UK has used a single use camera.

Kodak Ltd.
Tel: 01442 261122.

Win a trip to Paradise with FosterGrant

FosterGrant is running an in-store promotion for its sunglasses this summer. A lucky customer will win a trip to Paradise Island – the honeymoon destination for supermodel Cindy Crawford.

The promotion will feature Cindy in her FosterGrant sunglasses against a backdrop of a beach on Paradise Island. Leaflet dispensers will also be affixed to the sunglasses display.

The promotion will run from May until September 29 and the winner will be selected at random in October.

AAi FosterGrant Ltd.
Tel: 01782 577055.

The sky's the limit for Benadryl

Warner Lambert is supporting its Benadryl brand with a £4 million marketing campaign, which includes press and outdoor advertising, training seminars and PoS materials.

A Benadryl hot air balloon will tour the country throughout the spring and summer months, flying at major national outdoor events and country fairs. The giant 100ft high balloon is designed to glow when it flies at night.

Public flights in the balloon can be won through newspaper competitions and funds raised from tethered flights will be donated to the British Allergy Foundation.

During National Allergy Week (May 15-21) the balloon will be flying over Bristol, Plymouth, Birmingham, Manchester, Leeds and Norwich to raise awareness of hayfever and other allergies at peak times of suffering.

Warner Lambert Consumer Healthcare.
Tel: 023 8064 1400.

ActivHeal hands out the samples

An extensive sampling campaign for Savlon ActivHeal, started at the London Marathon, will continue through the summer at major athletics events. These will be at Loughborough, Bedford, Cardiff, Glasgow, London (Crystal Palace), Birmingham and Gateshead.

Savlon ActivHeal is currently being supported by a £1.2 million advertising and promotional campaign begun in April. There are seven SKUs in the range which caters for blisters, cuts, grazes and burns.

Novartis Consumer Health.
Tel: 01403 210211.

ON TV NEXT WEEK

Benadryl Allergy Relief: All areas

Clearblue Home Pregnancy Test: G, A, W

Fybogel: G, Y

Gillette Mach3 razor: All areas

Oxy: All areas except U, CTV, GMTV

Oxygen: All areas except U, CTV, GMTV

Radox Showerfresh: GMTV, ITV, C5, Sat

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

NAME

Age if under 12 years	
yrs.	mths.

Address

Pharmacy Stamp

Pharmacist's pack & quantity endorsement	No. of days treatment N.B. Ensure dose is stated		NP	

150 x Paracetamol 500mg tablets

Two tablets up to four times a day, when necessary

A patient presents this script from your local nurse prescriber on an FP10PN, and properly written and signed. Your dispensing technician knows it cannot be dispensed, but does not know why. Can you explain? The Pharmacy Practice Unit at King's College, London, provides the answers

Question

Why can't you dispense this prescription?

Answers

This item cannot be dispensed, although from the Nurse Prescribers' Formulary in the standard edition of the *BNF* it might appear that it can be. This list includes Paracetamol Tablets BP as a prescribable preparation without further comment.

However, the Nurse Prescribing List given in Part XVIIIB of the Drug Tariff states that only quantities of up to 96, in packs of not more than 32, may be prescribed. The explanation for this can be found in the List of Medicines for Human Use in Medicines, Ethics and Practice, where it can be seen that paracetamol is classified as a POM except in quantities of up to 100 in packs of not more than 32, under which circumstances it is classified as P.

Nurse prescribers are permitted to prescribe only a very limited number of POMs, and paracetamol is not one of them.

The maximum quantity of paracetamol that a nurse prescriber can prescribe is therefore 96, and the tablets cannot be supplied in a single container but in packs of 32 at the most.

To walk in, or not to walk in – *that* should be the question

It is his usual incisive manner, **Xrayser** has highlighted the double-edged nature of the relationship between pharmacy and walk-in centres (*C&D* April 15). **Xrayser** suggests that walk-in centres should be the exception to the norm. I would go further and query whether they are needed in the first place.

Walk-in centres are to be located at convenient sites, offering ready access to a healthcare professional, treatment for minor injuries and illnesses, health advice and information and other local services. Such centres already exist in abundance; they are called community pharmacies. We continue to push this point with the Government.

Notwithstanding our concerns, walk-in centres are a political imperative for Government and an important part of its NHS modernisation agenda. Just under 40 of these new centres will open during the year. We, therefore, need to understand fully how they will impact upon NPA members and develop a strategy for establishing an environment in which community pharmacy and walk-in centres can co-exist.

This strategy needs to deal not only with the threat posed to pharmacy by walk-in centres, particularly as they will provide medicines, but also to realise the opportunities they create. One possible opportunity is for pharmacies, in appropriate circumstances, to host a walk-in centre.

Xrayser is also right to say that some pharmacies will be more suitable than others. But the same is true for many NHS services, including healthy living centres, provision of warfarin monitoring services, needle exchange schemes and supervised methadone administration.

There is no blue print for the structure of walk-in centres. At the moment, they are accommodated in substantial premises in areas of high population. But there could be a different model in deprived areas or suburban areas which would not sustain large premises and where walk-in centres can be integrated into the pharmacy.

In this case, it would not be necessary for a pharmacy to have large premises to accommodate a walk-in centre since the main work of such a walk-in centre – dealing with minor ailments and injuries – could be integrated into the work of the pharmacists and pharmacy staff. This seems to us to be a more desirable outcome than a scenario where others control the future development of walk-in centres and community pharmacy is excluded completely.

John D'Arcy
Director, National Pharmaceutical Association

Inclusion delay costing pharmacists thousands of pounds

Pharmacists who have dispensed the new Nutrison Multifibre and Paediasure with fibre between July 1999 and April 2000 are losing 12 per cent or more. The Prescription Pricing Authority does not regard them as zero discount lines as they were not listed in the Drug Tariff as ACBS (Advisory Committee on Borderline Substances) approved, despite ACBS approval when launched last summer.

This delay between approval and inclusion in the Drug Tariff is costing pharmacists thousands of pounds as prescriptions for these products tend to be of high value (£100 or more) each. The PPA automatically includes these products in contractors' discountable goods without informing them.

The ACBS should also be legally liable for following through its job and ensuring that once ACBS status is granted the product is included in the Drug Tariff. If contractors were to perform as badly they would be prosecuted by the fraud squad.

Pharmacists should be warned to check the ACBS status of these feeds before dispensing them, even though failure to dispense them "within a reasonable time" would be an offence.

Perhaps a reasonable time would be considered to be one in which the contractor did not make a loss, ie wait until they appear in the Drug Tariff.

Nicholas Gompels
Devizes

Nursing home appointment is not a realistic proposition

Like Isle of Wight LPC, we at Merton, Sutton & Wandsworth LPC are concerned about the future appointment of a nursing home pharmacist by the Isle of Wight Health Authority. It is not workable in real life.

At present, pharmaceutical advice to nursing and residential homes is available from their chosen local pharmacist throughout the working day without delay. Will the newly appointed pharmacist be available to all the homes at all the times that the pharmacy is open? Who will deal with the medication of the new patients admitted to homes, which can happen at any time of the day? Who will answer to product availability, especially dressings and appliances, on a day-to-day basis? Will the HA pharmacist deal with all interactions and side effects that arise from medicines prescribed for the residents. Urgent requests for changes to alternative dosage forms have to be addressed promptly; who will deal with that?

In the first instance, contractor pharmacists should withdraw supply of monitored dosage systems to the homes, or a realistic charge should be made for supplying these systems and the paperwork. Contractors should not answer any queries and see if the HA pharmacist can cope with day-to-day routine queries from the homes.

If the HA can afford to employ such a pharmacist then it should be able to pay realistic fees to contractors for the services they provide to homes. There is no point falling for the carrot of 'other initiatives' which really should come from new monies and savings from prescribing costs.

Paresh Modasia
Chairman, Merton, Sutton & Wandsworth LPC

Why spoil a good story with the facts?

The media gave wide coverage to the recent paper in *Thorax* appearing to associate asthma with frequent use of paracetamol.

Very few titles covered the statement issued the same day by the Medicines Control Agency, which stated that the Committee on Safety of Medicines had reviewed the study and concluded that "there is no reason for advising any change in the use of paracetamol. Paracetamol is a safe and effective pain killer for many patients including asthmatics".

Was this a case of 'Why spoil a good story with the facts'?

Furthermore, few of them mentioned that the authors clearly stated they had no evidence for a causal effect, or the opinion of at least one asthma specialist who commented that the impaired sleep suffered by severe asthmatics gives rise to frequent headaches – the main reason for taking paracetamol expressed by participants in the study – so that the asthma may increase the use of paracetamol rather than the other way round.

Dr Geoffrey Brandon
Paracetamol Information Centre

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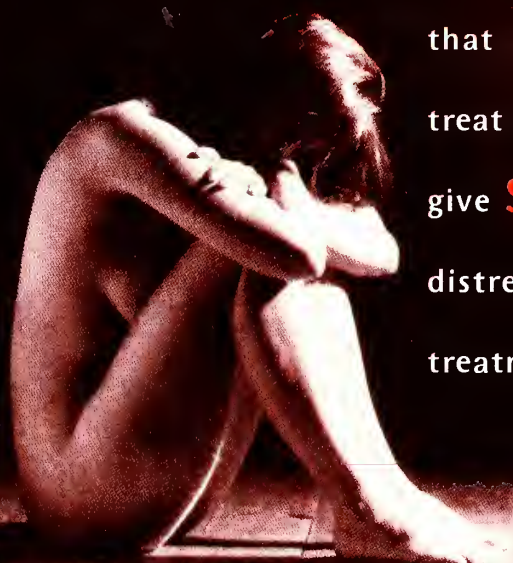

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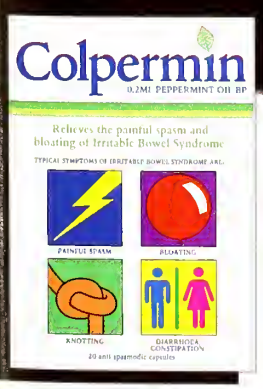

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News from Germany

Thumbs down from Germany's 'Which?'

Many German drug manufacturers are furious with the country's national equivalent of the Consumers' Association, which recently published a book intended for patients and medical practitioners that is highly critical of some 25 per cent of 5,000 of the country's most widely used medicinal products.

The Drugs Handbook (the cost of which, at about £25, may hopefully put many people off buying it, according to one pharmaceutical commentator) weighed up the risks and benefits of mostly prescription drugs and evaluated their therapeutic effectiveness.

The authors, a biologist and a pharmacist, assisted by another pharmacist and eight doctors, then placed them in four categories ranging from 'suitable' (ie proven effective in the stated indication and with a positive risk-benefit ratio) to 'of little efficacy'. A quarter of all products received the latter verdict.

Predictably, it is this 25 per cent that the media have seized upon. The handbook editor is a well-known critic of the German pharmaceutical scene, and the book seems to have stirred up the same furore as the diatribe against the pharmaceutical industry, 'Bitter Pills', published back in 1983.

Once again, old favourites such as the combination of aspirin, paracetamol and caffeine, as well as ointments for venous complaints, come in for heavy criticism. But with a staggering 45,000 products still on the German market, the book's authors may well have a point and it may help the Health Minister in her attempt to publish a 'negative list' this summer.

Upper House foils health plans

The plan by Germany's 'red-green' coalition government to legalise 'fixer rooms' where drug addicts would be allowed to inject themselves using supplied syringes under supervision has been rejected by the Upper House of Parliament.

The proposal was merely to allow those regions, which so desired, to set up such centres, not to force them to do so. Opponents of the plan said it would send the 'wrong signals' and questioned whether such centres were actually effective in their ultimate aim of persuading addicts to give up their habit.

The Federal Health Ministry had also wished to set up a reporting system and methadone substitution register for opiate addicts and intended to require doctors who prescribed methadone, to be specially qualified.

Drug overspending fears not realised

The Health Minister's worst fears of severe budget overshoots in health expenditure among the statutory health insurance schemes in 1999 were not realised, according to preliminary figures issued in March that actually showed a slight surplus.

However, expenditure on drugs rose nationwide by over 8 per cent and this was blamed by the Health Minister for spoiling the financially balanced picture in other areas of healthcare.

A spokesman for pharmacists archly pointed out that the surplus could have been doubled, had the government not reduced prescription charges and the rise in the drugs bill did not take account of this politically motivated action.

In fact, the increase was not due to doctors prescribing more drugs at all, but rather a switch to the newer, more expensive treatments for diseases such as diabetes, Alzheimer's disease, cancer, MS, heart failure and ulcers.

Generics now account for 70 per cent of the market and the prices for the older drugs subject to a reference price showed no rise during the year.

The statutory health insurance schemes face further calls on their finances following a court decision that they must, after all, pay for ICSI (intracytoplasmic sperm injection), the costly additional IVF treatment for male infertility.

Since its introduction into Germany six years ago, 10,000 babies owe their existence to this treatment, which can cost parents over £3,000 per treatment cycle.

Stange in the dock once again

The long running battle between pharmacist and business man Gunter Stange and Germany's pharmaceutical authorities has yet again surfaced in court, in full media spotlight.

The story behind the allegations, that Mr Stange has attempted in various ways to circumvent the law that requires every pharmacy to be personally run by a pharmacist who can only own one pharmacy at a time, seems to be getting murkier by the day.

Some 100 witnesses were expected to be called after Mr Stange's lawyers failed in their opening bid to have the charges against their client withdrawn until the German constitutional court and the European court had reached a decision on the legality of the ban.

Citing the examples of the UK and Italy, where the presence of multiples was said not to endanger either the proper supply of drugs or public health, his lawyers maintained that Mr Stange had actually been inspired in his actions by a trip to England organised by a pharmaceutical wholesaler.

Between 1982 and 1989, Mr Stange was said to have had many negative experiences when attempting to buy his own pharmacy, even being given figures purporting to be for daily turnover that related to weekly sales.

He had then resolved to help fellow pharmacists by giving them advice and information. Allegedly against the wishes of ABDA, he had decided to set up pharmacies in down-market shopping centres. He then established two companies, of which he was temporarily managing director, concerned with renting premises to doctors and pharmacists and the selling of pharmacy equipment, outfitting and marketing.

He now faces over 53 charges ranging from infringing the ban on multiples, incitement to fraud, instigating false statutory declarations and illegal financial dealings.

Many pharmacists appear to have been attracted by his offers of £30,000 a year, a 40 hour week and five weeks holiday a year. But they have since fallen into debt or experienced difficulties when attempting to extricate themselves from complicated short-term leasing or renting contracts.

The case is becoming dirtier as charges and counter charges are bandied about and 24 pharmacists caught up in the affair have now refused to testify, possibly because they are still involved in lawsuits with Mr Stange or one of his companies.

The German weekly news magazine *Der Spiegel* (itself recently accused of paying over £30,000 for 'information' from a key witness in another court case) reported that one high ranking member of the ABDA executive sought personally to help prosecution witnesses.

Der Spiegel alleges that a woman pharmacist from Munich was offered about £4,000 to come forward and was promised help 'through political channels' to enable her foreign partner to gain German citizenship. ABDA headquarters has refused to comment on this allegation whilst matters are still sub judice.

This situation looks set to continue for a long time, as no end to the trial is yet in sight. If found guilty of running pharmacies illegally, Stange faces up to six months in jail or a fine equivalent to six months income.

Meanwhile, the authorities in Berlin have searched five pharmacies in the city which they suspect are part of a chain owned by a pharmacist, who in addition to his own shop, is thought to be personally and financially involved in four others run by front men.

No to the morning after pill

Unlike their counterparts in pilot projects in the UK and France, German pharmacists, although angry at being excluded from the distribution loop for the newly licensed morning after pill (see *C&D* October 16, 1999), have no wish to be allowed to dispense it independently.

The president of ABDA believes there are no indications that any woman in need of emergency hormonal contraception is unable to obtain it from current channels. He also recognises that, on grounds of conscience, some German pharmacists would not wish to supply it.

With an under 18 pregnancy rate of only 0.6 per cent (the European average is between 2-6 per cent), the Government has said it has no plans to distribute EHC free to schoolchildren.

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Clive Jackson – Director, National Prescribing Centre

It is both an exciting and anxious time for pharmacists. Rapid reform of NHS structures is linked to extended roles and accountability for professionals. And there is a whole new vocabulary used within important initiatives – clinical governance, risk management, patient group directives – which means that pharmacists, as never before, need to be up-to-speed with the evolving environment.

You can only grasp opportunities if you are aware of them, and have the right knowledge and expertise to undertake them. These three articles provide an overview of just a few of the key issues now facing pharmacy within primary care.

The first article sets out the importance of effective training and development, and provides pointers to a new resource document aimed at helping pharmacists identify gaps in their skills and how to go about filling them. The second looks more closely at some of the key issues around quality improvement within primary healthcare, and how pharmacists can get involved in this process within a multidisciplinary environment.

The final article provides details about clinical governance, improving quality and the process of change management. Clearly, identifying a problem area within professional practice is only a first step. Effective action needs to be planned, implemented and then reviewed to ensure that the change identified is both effective and beneficial to patient care.

I hope that you will find these articles of interest and value to your understanding of the evolving NHS, and that they will stimulate you to look more closely at what you currently do and what new roles you might be able to take on in the future.

Competencies for primary care pharmacists

Clive Jackson discusses competencies in primary care and a new framework document for pharmacists launched by the NPC last week

The NHS is changing rapidly, providing important opportunities for pharmacists to extend their current roles and carve out new ones.

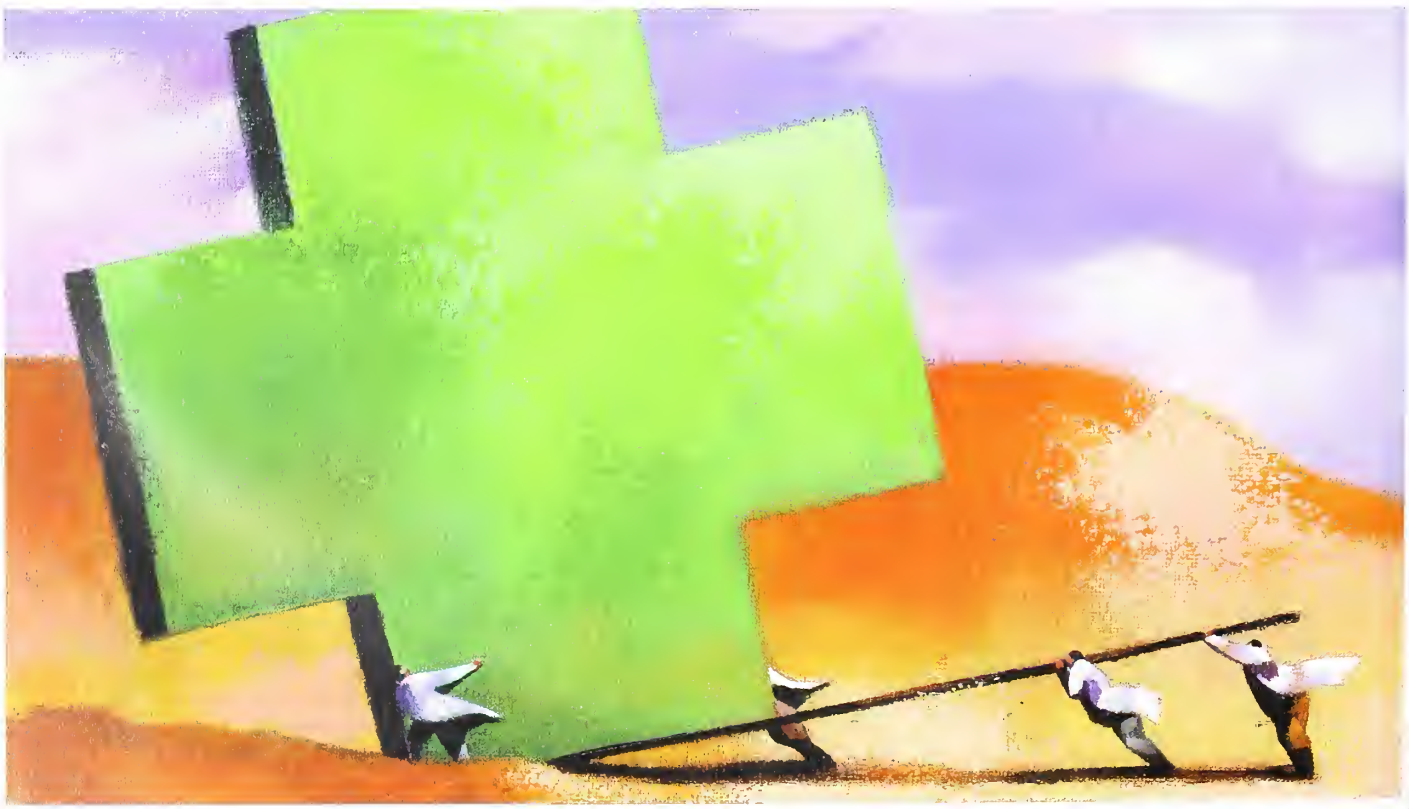
Clive Jackson

Nowhere is this more evident than in primary care, where pharmacists can support GPs to ensure high quality, cost-effective prescribing within practices, and primary care groups (PCGs) and trusts (PCTs).

As with most jobs, once in post the roles that pharmacists are asked to undertake usually expand. Initially employed to provide routine support specifically around GP prescribing (eg PACT analysis, formulary development, generic switching), pharmacists are now increasingly being asked to take on new responsibilities.

This is a positive sign. Helping to manage the financial risk around prescribing within unified, cash-limited budgets locally is, and will remain, an important role. However, the profession can only benefit from individuals moving much more into the quality agenda around wider patient care.

This is where some of the long-term aspirations of pharmacists working for these organisations should be heading.



Pharmacy support for PCGs

The number of pharmacists recruited to provide prescribing support has grown rapidly over the last 18 months. Currently, the National Prescribing Centre (NPC) has over 580 on its advisers' database now working within PCGs or GP practices. This group is over and above the 180 or so pharmaceutical advisers still working at health authority (HA) level.

Of the 481 PCGs in England, 87 per cent currently have access to pharmaceutical input around prescribing. Some 68 per cent of these, directly or indirectly (through their HA), employ pharmacists, either on a part-time or full-time basis, while 38 per cent are buying input, on a sessional basis, directly from community pharmacists.[1]

Individual GP practices also, on occasions, directly fund sessional pharmaceutical input, again usually from community pharmacists.

Why be cautious?

So why do we need to tread carefully in what appears currently to be such a positive environment for pharmacy?

When any change is made rapidly, it is often the case that some planning is carried out 'on the hoof', and that compromises are made to get the job done within the time available.

The recent, and often ad hoc, dash to recruit prescribing support and advice inevitably means that there is now emerging, within this new pharmacist group, a broad spectrum of skills, knowledge and expertise.

A significant minority of these pharmacists already have the skills to carry out most of the tasks they are being given and are doing an excellent job. Others have a good proportion of the required skills and, with the appropriate training and support, will soon grow into their new roles.

Unfortunately, a small proportion of those pharmacists now employed within PCGs and GP practices, do not yet possess the right expertise, and may not realise that they don't.

The profession must, therefore, work quickly to ensure that primary care pharmacists identify the competencies now needed to carry out particular roles and that they are given the appropriate incentives and support to address them.

Accountability

Recent high-profile tragedies and court cases involving pharmacists and doctors have added impetus to the Government's desire to address professional accountability, continuing development, competence to practice and regular re-accreditation.

Pharmacy, like all the other healthcare professions, will have to address these issues with careful planning and the development of frameworks against which to judge the effectiveness of professional practice.

To kick-start this process for those pharmacists now working within the evolving PCG, PCT and GP practice environments, the NPC and the NHS Executive are developing a core competency framework. The document, 'Competencies for Pharmacists working in Primary Care', will be launched and disseminated widely during April and May.

Both the NPC and the NHS Executive expect that this will also stimulate providers of education and training to refine existing courses, or to develop new ones to meet the new demands. Let us hope that with the appropriate support, primary care pharmacists will quickly rise to the challenge of optimising their skills and knowledge to ensure that, in the long term, the opportunities now emerging in the new NHS become reality.

Competency frameworks in use

What is a competency framework? A competency is a quality or a characteristic of a person that is related to effective or superior performance in their work.

Competencies can be described as knowledge, skills, motives or personal traits. A core competency framework is a collection of those competencies thought to be central to effective performance within a related group of roles or jobs.

Competency frameworks can be used to support a number of activities including recruitment, performance review and training and development. 'Competencies for Pharmacists working in Primary Care' has been developed primarily to aid identification of the training and development needs of primary care pharmacists. However, this document can also be used by both pharmacists and their professional/managerial colleagues to assist effective recruitment.

Use of the competency framework will involve three main steps:

- **Competencies it contains must be tailored to the specific roles or job being assessed**
- **Pharmacists (and their peers) must assess whether they exhibit the competencies identified and, if not, where the gaps in training and development are**
- **Individuals (and their employers) must identify what type of training or development is appropriate, available and realistic for the individual to undertake.**

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1. Cantrill J, Devlin M, Jackson C, Queenborough R. 'Quality Street: why wait to be asked?' Pharm J 2000; 264, Broad Spectrum (in press)

The quality agenda in primary care

Maureen Devlin and Judy Cantrill, of the National Primary Care Research & Development Centre, Manchester, look at what makes for quality in primary care

The drive to measure and improve quality is a key element of the Government's agenda for the NHS. Policy changes such as the mandatory grouping together of GPs into primary care groups and trusts, and the requirement for local clinical governance arrangements (see p24), have been introduced to help reduce variation and improve standards of care.

In this article we will provide a definition of quality in primary care, relate this to pharmaceutical care, and discuss the responsibilities and opportunities for community pharmacists in moving the quality agenda forwards.

Quality care

The quality of patient care has three main elements: effectiveness, access and equity of care that must be underpinned by good management and sound, continuing professional development.

Clearly, the supply of medicines and related advice-giving falls within each of these elements. More specifically, quality in relation to pharmaceutical care includes:

- ensuring that the patient receives safe, effective and appropriate treatment at the right time
- ensuring that the patient receives appropriate information about their treatment
- ensuring that treatment and advice is provided by an appropriate professional in the most cost-effective way
- looking at the upsides and downsides of treatment (including any financial impact to patient or GP budget)
- identifying ways to promote and maintain health, as well as treating illness.

How is it assessed?

Last year, the National Primary Care R&D Centre published the first of a series of practical quality assessment guides for health professionals in primary care. It listed the topics that general practice teams should focus on when they are looking at the quality of their practice[1].

This handbook also provided indicators of high quality that teams could use in areas such as the management of chronic conditions, preventative care and health promotion and prescribing patterns

Maureen Devlin

Judy Cantrill

Continued on P22 →

Guest editor

→Continued from P21

As part of this series, a handbook has recently been produced that focuses specifically on the areas in which pharmacists are already - and will be increasingly - playing an important role[1].

These areas include prescribing review (clinical and cost variation), managing repeat prescribing, development and application of clinical guidelines, formulary development, managing the introduction of new drugs and the delivery of high quality pharmaceutical care.

So, how can pharmacists working either full-time or on a sessional basis with practices and PCGs, assess the quality of these activities?

Prescribing review

Primary care groups and trusts have to manage their prescribing costs within a wider unified, cash limited budget. The vast majority of PCGs are employing pharmacists either full-time or on a sessional basis to manage their prescribing.

There is some evidence that PACT-based prescribing indicators are being used inappropriately. Pharmacists need to be clear about whether they want to look at quality or cost minimisation.

While PACT data may be appropriate to compare and monitor costs, resource intensive audit of individual patient records is required to assess quality.

- All indicators need to be applied and interpreted with caution. No single indicator can itself define the quality of care. A true assessment of quality is labour intensive and can only be achieved by audited care for individual patients.
- For some conditions, PCGs will need to have a strategy to increase selected prescribing in order to improve the quality of care provided (eg statins).

Repeat prescribing

A good repeat prescribing system has the following three components in place:

1 good administration that ensures requests are dealt with efficiently and effectively

2 good management to prevent abuse of the system, to minimise waste and to make sure that the review happens at the right time

3 good clinical practice through face-to-face comprehensive medication review.

Pharmacists should work with their local practice and PCGs to ensure they have robust repeat prescribing systems and that effective medication review takes place.

- The presence of a robust repeat prescribing system is a proxy quality marker for general practice care.

Clinical guidelines

There are key challenges for pharmacists in supporting the implementation of national guidelines - such as those from the National Institute for Clinical Excellence - the assessment of existing guidelines and also the development of local guidelines.

The function of guidelines is to help health professionals deliver care based on the best available evidence, not to mandate or outlaw particular treatments.

- PCG pharmacists should review national guidelines to identify the impact on pharmaceutical care and ensure that local community colleagues are aware of the implications - the financial and organisational implications of guidelines need to be considered before implementation.

Formularies

Most doctors tend to prescribe from a fairly narrow range of drugs and the development of a formulary is a natural extension of this practice.

The challenge is to gain agreement on a joint list within a practice or PCG, recognising that GPs should retain their individual clinical freedom to prescribe for a patient as they see fit.

The development of formularies should also not be purely based on GP prescribing, but should involve nurses too in the areas where they have considerable control over prescribing decisions (eg wound management).

- The development, use and regular review of a practice formulary is a proxy marker of quality.

New drugs

Managing the uptake of significant new drugs into the NHS in an effective way will remain a priority for PCGs and health authorities. Pharmacists in these organisations collectively have an important role to play in planning and implementing the agreed process.

Some new drugs will be subject to review by NICE, and then national guidance will be provided on how they should be used in primary care.

- Pharmacists need to understand the various mechanisms that now support and inform managed entry. Regular access to the relevant bulletins and guidance is recommended.

Pharmaceutical care

Pharmaceutical care has been discussed in the UK for nearly two decades, yet little progress has been made in practice. Quality improvement and clinical governance provides the ideal framework within which it can be progressed.

To deliver the huge quality agenda within the NHS, and to achieve the standards of care described in the National Service Frameworks (NSF), PCGs will need to ensure that they make optimum use of all the resources available to them.

These are likely to include the skills of community pharmacists, particularly in areas such as smoking cessation and healthy eating within a local strategy aimed at tackling heart disease.

Pharmacists also clearly have a role in supporting delivery of the local health improvement programme (HImP) in the management of chronic conditions such as asthma (medicines management) and in palliative care (supply).

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3. MeReC Bulletins. National Prescribing Centre (NPC), Liverpool. New Drugs in Clinical Development Bulletins. NPC in collaboration with UKDIPG.

Continued on P24→

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Guest editor

Annie Coppel, of the National Prescribing Centre in Liverpool, offers some guidance on how the ideals of clinical governance can be put into practice

Making change happen through clinical governance

You or your family, at some point, will have experienced the NHS as a patient. How often have you made comments about what, in your opinion, could have been done or handled better?

As users, we have valid, high expectations about the quality of care provided to us. But as providers of healthcare ourselves, do we regularly review, and try to improve upon, the quality of services we offer to patients, the general public and other healthcare professionals?

The Government is committed to ensuring that quality is at the heart of all services provided by the NHS. Clinical governance is the structural plan through which it can be delivered. However, this should not be seen as a completely new initiative, as many of its components have been established practice for some time (see Figure 1).

But if you ask several people what clinical governance means to them, you will probably get back several different answers, as they will define it in terms of the component they are most comfortable with.

However, as a profession with the ability to deliver and support high quality patient care, all components of clinical governance need to be fully embraced by pharmacy. Not only must they be addressed intra-professionally but also jointly with professionals from other disciplines.

The reorganisation of primary care – the evolution of primary care groups and trusts – has created new opportunities for pharmacists to become more fully integrated into primary healthcare teams and to be more closely involved in the wider healthcare agenda.

Within national and local health priorities, reflected in health improvement programmes, there is a range of prescribing and pharmaceutical issues that pharmacists can make important contributions to.

For example, in the delivery of the Cardiovascular National Service Framework there are roles to provide health promotion on smoking cessation and healthy lifestyles, to work with practice teams to audit current prescribing and to help develop an evidence-based approach to prescribing.

Annie Coppel

Figure 1: The components of clinical governance[1]

- Quality improvement
  - audit
  - education and training
  - continuing professional development
  - evidence-based practice
- Risk management
- Research and development
- Measures for improving professional performance

Whatever part you play in improving healthcare, be it supporting patients or professionals, you will be trying to help bring about change. Unfortunately, many well-trodden paths, for example, the provision of educational literature or didactic education meetings, are rarely effective on their own.

Facilitating change, especially for the better health of patients, can require major alterations in behaviour and culture. However it is not a simple process and you cannot change everything at once.

Effecting change

To introduce change effectively, it is important to understand the factors that make a change more likely to be accepted and adopted, and the strategies you can employ.

There are many barriers to change, not least the anxiety and resulting resistance this can cause. Being aware of these, and knowing how to overcome them, is also critical.

Irrespective of the magnitude of the change being proposed, be it reducing prescribing of trimethoprim for urinary tract infections from seven to three days, or introducing a computer into a paper-based practice, there needs to be a clear and agreed vision why the change is required.

Everyone who will be affected must also appreciate the benefits (and any drawbacks) the change will bring, and be able and willing to take the desired action.

Changes are more successful if what you propose is:

- perceived as offering advantages
- perceived as being compatible with the current situation
- simple
- able to be tried out before committing fully
- visibly beneficial.

Presenting a plan to take the initiative forward is also crucial, because without an acceptable first step the change is unlikely to occur.

Deciding whom to target first is also important, as you will find that individuals within the primary healthcare teams you are working with, will vary in their response to change. Five categories of individuals have been defined[2] (see Figure 2).

> "If you are to act as an agent for change you need to understand your role and what it involves"

Initial efforts are best concentrated on the innovators and early adopters. They will lend confidence and credibility to the change and will respond faster than other types of individual.

Each type is most likely to be influenced by those whose perspectives are closest to them. Therefore, early adopters, perhaps a PCG prescribing lead, will talk to the early majority, eg GPs in training practices, and by targeting the right people, a critical mass for change can be achieved.

If you are to act as an agent for change you need to understand your role and what it involves. For example, are you:

- leading the change – having the vision, communicating it and inspiring others to change?
- managing the change – implementing it by planning, organising and solving problems?
- facilitating the change – easing everyone through the process by suggesting methods and encouraging participation, remaining neutral?

Priorities set within the clinical governance agenda mean that PCGs and their constituent practices will be looking at ways of making changes.

With the increasing emergence of antibiotic resistance, the effective use of antimicrobials is a national priority for action. Pharmacists are ideally placed to help reduce inappropriate antibiotic prescribing, but whatever role you play, you will maximise your support by realising the concepts and theories behind change management.

The NHS, now more than ever, offers many exciting opportunities for pharmacists to help deliver the quality agenda. Before you can actively contribute you need to understand how to make change happen, and you may need to make changes to your own practice and behaviour. Are you ready for the challenges ahead?

Managing change

To help PCGs, the National Prescribing Centre has developed a structured set of resources entitled 'Putting Clinical Governance into Practice: Managing Antibiotic Resistance – a practical guide'.

Although based around antibiotic prescribing they have been developed so they can be adapted for use in introducing any other change in healthcare delivery.

The resource essentially consists of three packs:

- Pack 1 is a self-study guide for local facilitators and covers the key theories, research evidence and practical skills required to change prescribing behaviour.
- Pack 2 consists of two workshops for PCG members, especially the board, designed to help them develop and implement an effective and consistent antibiotic policy across its constituent practices.
- Pack 3 is aimed at GPs, their practice teams and other primary care professionals. It consists of three workshops, two about consulting with patients and a third to engage wider practice/primary care teams.

This resource provides a focus around which PCGs can build, ensuring a reduction in inappropriate antibiotic use in line with clinical governance priorities and national guidance. It is available to health authorities and PCGs from the spring, and although primarily targeted at clinical governance and prescribing leads, it will be of interest to anyone involved in prescribing and training.

While identifying problem areas of practice and taking corrective action is an important step, you also need to monitor what you expected to happen is actually happening, and the anticipated benefits to patients are being delivered and maintained.

To support primary care pharmacists in this role, the NPC and Royal Pharmaceutical Society has developed an Audit Handbook entitled 'Practical clinical governance for primary care pharmacists: Managing Antibiotic Resistance'.

Distributed to health authorities and PCGs during April, this will complement the comprehensive change management resource described above. The Audit Handbook will soon also be made available to local pharmaceutical committee secretaries.

Figure 2: How individuals approach change

Category	Characteristics	Action for change
1 Innovator	Adventurous, copes with high degree of risk; can understand and apply complex technical knowledge	None
2 Early Adopter	Local opinion leader, successfully adopts change	Mention it
3 Early Majority	Open minded but cautious; interacts frequently with peers	Show working example
4 Late Majority	Conservative, sceptical, motivated by peer pressure	Prove it
5 Laggard	Traditional, isolated	Change the rules

1. Clinical Governance Quality in the new NHS. Leeds: NHS Executive. 1999 (HSC [99] 065)

2. Rogers E. Diffusions of innovations. New York Free Press 4th Edition

Few pharmacists or other health professionals drop out of the alcohol and drug dependence treatment programme at Birdsgrove House, although drugs are withdrawn from day one. The director, Rory O'Connor, tells Adrienne de Mont how he and his team approach a difficult treatment group

On course to beat the habit

Health professionals who become dependent on drugs or alcohol have great difficulty in coming to terms with their problem. Denial looms large in people with high professional standards who are used to being the prescribers rather than receivers of treatment.

"Their history and philosophy is all about giving to others, so they have difficulties with failures in themselves," says Rory O'Connor, Birdsgrove House director. "They serve the public, and have great professional and personal pride. They tend to be perfectionists who like to see order in their own lives. When this is challenged – particularly by addiction – they have a tremendous sense of failure. We have to convince them that they are exposed to the pressures of living, just like anyone else."

Little is known about what drives pharmacists to drink or drugs, as rehabilitation programmes specifically aimed at health professionals have been running for only about five years. Although genetic factors play a part, the pressure of public expectations – of always having to get things right – have a profound influence. For independents, the sense of isolation is more likely to tip the balance than financial pressures. Life is no easier for employees, as the multiples have high expectations of their managers.

Birdsgrove House offers a place for relaxation, as well as help for addiction

By its nature, drug dependency creates further isolation.

"It is unacceptable in our society to use drugs or alcohol to excess, so if you have an increasingly antisocial habit it isolates you even more," says Mr O'Connor. "You don't get many alcoholics going into pubs. What starts as social drinking gradually progresses to solitary drinking, even though the person may be surrounded by customers, work colleagues and family."

By June the first group of clients using Birdsgrove House's drug dependence unit will have been out of treatment for six months, so he should have statistics for a full year since the opening in November 1998. Over the next few years, patterns should emerge in the factors leading to dependence and the types of drugs most often used.

His impression so far is that alcohol gives pharmacists the most problems, but there are no clear trends in drug use.

Age is no barrier. Patients at the unit have ranged from undergraduates to the over 70s. Alcoholics are mostly in their late 30s/early 40s, while drug abusers tend to be about ten years younger.

The unit is licensed for 12 beds but he takes no more than seven patients at a time because of the need for individual attention.

"The first year has surpassed all our expectations," he says. "An average of 5.2 clients has embarked on each five week programme, so there have been over 50 admissions from as far afield as the Scottish Isles and the south west. By February we had treated 20 pharmacists, 17 dentists, 12 doctors, four nurses and two vets."

Mr O'Connor is a nurse, counsellor and psychologist who has worked for 30 years in the NHS, private and charitable sectors. Since the early 1980s he has focused on alcohol and drug dependence in health professionals, latterly at the specialist unit, Foxleigh Grove, near Maidenhead. While most pharmacists now come for treatment at the Royal Pharmaceutical Society's Birdsgrove House, Foxleigh is still an option for those who feel the former is too closely affiliated with pharmacy.

Mr O'Connor heads a team of five nurses, who provide 24-hour cover, and four counsellors. The nurses' role is to keep an eye on the patient's mental and physical health, and to manage the detox programme as prescribed by a doctor. The GP visits regularly and is on-call 24 hours a day for Birdsgrove's convalescent guests as well as the addicts. A psychiatrist also assesses patients throughout the five-week programme.

A physiotherapist prescribes exercise, and offers massage and aromatherapy which can help relaxation during detox.

Continued on P28 →

Birdsgrove – to rest and de-stress

Pharmacists wishing to spend time at Birdsgrove House for convalescence or relaxation are guaranteed the same welcome and high quality service as they were before the drug dependence unit opened, says Mr O'Connor.

The health professionals undergoing treatment for drug dependence live separately from the convalescent guests and there have been no complaints about the mixed use since the new unit opened. Last September was the busiest month for five years for convalescent guests.

For the first time, the House stayed open at Christmas and the New Year, and there are plans to do similar short breaks this year.

Mr O'Connor is also organising, with the Society, weekend stress relief programmes.

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→Continued from P26

The first step

Usually a family member first reports a dependency problem to the Society.

An intervention team, led by Joe Mee, sees the pharmacist at home and talks to the family, seeking evidence that the problem is real and not just a malicious rumour.

Dennis Lynch, one of the counsellors, says ten to 15 minutes is enough to make a decision.

"Usually, by this stage in his or her illness, the pharmacist is aware that something is wrong, so we try to persuade them, without undue pressure, that it would be in their best interests to come here. They need to want to do so, because they can recover from addiction only if they want to. It's an illness that tells us we haven't got it, so denial is a big problem. Addicts know their lives are not good but they are oblivious to the wreckage and destruction they've left around them."

This 'wreckage' could include drink-drive charges, financial difficulties, relationship breakdown, and problems at work through dishonesty and unreliability.

Beverley Nicol, the Society's welfare officer who organises support for the families, says: "We usually find the problem has been going on a long time, but the family didn't know where to turn. Often they are deeply ashamed, because of the health professional's public profile, so it comes as a great relief to find there is somewhere to get help."

Total abstinence is the only option and most patients are drug-free by the end of the first week. Substitution therapy is not used but group therapy and individual counselling helps them on the painful road to recovery.

The first step is to encourage the addict to examine his or her past and seek evidence that a problem exists.

"It's easy enough for me to tell someone with a five, ten or 15 year insidious history of alcohol or drug abuse that they have difficulties with physical, emotional, social and professional wellbeing. The difficulty lies in enabling them to recognise it for themselves," says Mr O'Connor.

The second week involves the patient accepting there is a need for change and exploring what change is needed. The third week is often pivotal in making a firm decision to change.

"The drop-out rate is virtually nil, which is outstanding. Fewer than 0.2 per cent of clients have failed to complete the five week programme," he says.

Is this because of the personality of those admitted – the same traits of perfectionism and pride that have contributed to the problem in the first place?

"To some extent, yes. But I think the success is also due to the commitment and dedication of our staff. Because of the small numbers of patients, the counsellors and nurses can have a more personal relationship. I'm a great believer in small groups, so I wouldn't want to expand here any further."

Future expansion would involve setting up similar small units in other parts of England, Scotland and Wales.

Week four is a reflective time during which clients explore themselves as individuals and examine the predisposing factors that could put them at risk of relapse.

"We also start developing the support systems and encouragement they will need when they leave. The fifth week is about endings and new beginnings, embracing the idea that a clearly defined support system will be there for them whenever they wish. They will already have been attending meetings of Alcoholics Anonymous or Narcotics Anonymous throughout their stay here. We follow them up regularly over the next 12 months and if they relapse they can be re-admitted for a short time. We see the programme here as just a foundation on which to work."

Success rate

The success rate – defined as total abstinence from the use of mood altering substances – is, at about 80 per cent, similar to success rates elsewhere in Britain and the US.

A possible setback for pharmacists addicted to drugs is that they will have to handle drugs when they go back to work. They must be taught how to resist temptation and feel confident about doing so before returning to practice.

Disulfiram and substitution therapy are not used because "ultimately the person needs to take responsibility for his own abstinence". But Mr O'Connor is examining the case for acamprosate in alcoholics who keep relapsing because of powerful neuropsychological cravings.

The five-week treatment and 12-month follow up costs £6,250, which covers all accommodation and the services of the multi-disciplinary team. This cost compares "extra-ordinarily well" with other drug rehabilitation centres, says Mr O'Connor.

In 94 per cent of cases the health authority in which the patient resides paid the costs. The remaining patients have paid for themselves or obtained interest-free loans from the Benevolent Fund.

- Clients are promised respect and confidentiality. Anyone who thinks they might have a drink or drugs problem is urged to contact the Pharmacists' Health Support Scheme's helpline (01926 315138) or contact Birdsgrove House, Mayfield, near Ashbourne, Derbyshire DE6 2BN (tel 01335 342144).

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Lloydspharmacy opens pilot 'health and wellbeing' store

Lloydspharmacy this week opened a pilot 'health and wellbeing centre' in Five Market Square, Sandy.

The 2,400ft² outlet, originally a traditional Lloydspharmacy store, is specialising in counselling, welfare and healthcare advice, although it still has a dispensary and GSL displays. It is not, however, selling toiletries, nappies and consumables. Lloydspharmacy has another store in Sandy which will meet demand for these products.

John Gregory, Lloydspharmacy's professional services manager, said the new centre had a different colour scheme to typical Lloydspharmacy outlets and cost three to four times as much to refit.

New features include an in-store CHAT centre (Community and local Healthcare, social and welfare Advice, provided by Trained professional advisors). Lloydspharmacy is already running CHAT centres in four areas, including Netherton, Alfreton and Burnley.

The store also has a fully fitted clinic with a sink and bed. Lloydspharmacy is talking to interested parties who could offer services through this area.

In keeping with its counselling image the store will have two pharmacists: Russell Foulsham is responsible for its counselling services, and the store is recruiting a pharmacist to supervise its dispensary. The outlet has three counselling areas.

Michael Ward, Gehe UK's chief executive, will formally open Lloydspharmacy's health and wellbeing concept store on May 5

Other new features include Intouch - the same touch-screen healthcare information system that Superdrug is using at Woolworths general store, although Lloydspharmacy has adapted the system to suit its needs. The software covers 1,600 topics which include herbal and specialised diets on the healthcare side, and pension planning on the social. Customers can search the system and print out whatever information they want.

Mr Foulsham said customers had reacted well to the system. Three had used it within one hour when the store opened on Tuesday morning.

Michael Ward, Gehe UK's chief executive, said the chain could ask manufacturers to sponsor the system. "We're trying to prove how successful its going to be, then we'll go and ask them whether or not they're prepared to sponsor it. But there are opportunities there," he said.

The store is also stocking a relatively large selection of vitamins and is offering anti-coagulant tests and aromatherapy.

Mr Gregory said the store would display blood glucose meters, nebulisers and diabetes-testing equipment openly, whereas most other pharmacies would keep this stock within their dispensaries.

A GP surgery is located behind the centre and is said to have reacted positively to the new concept.

Mr Ward said Lloydspharmacy will roll out other health and well-being centres gradually, depending on how successful the pilot proves. He will officially open the outlet on May 5.

Gehe boosts retail and wholesale purchasing group

Gehe UK has appointed Mark Green (below centre) as group buying director, with responsibility for both retail and wholesale activity. Mr Green, who joined Gehe in 1999, has a background in marketing and buying with High-Street chain Comet.

He will be supported by new director of OTC buying Janet Bridal, from the clothing and fashion industry, and Nick Jones (far left), promoted within the group to director of ethical buying.

Mr Green said: "At Gehe UK, as in many organisations, the demarcations between purchasing, marketing and even supply-chain are blurring. We have not re-structured but are focusing on creating a positive attitude across the group in order to work together to meet our customers' needs in the most efficient and effective manner.

"With a variety of backgrounds and wealth of experience we intend to develop the purchasing department and work together to raise the profile of pharmacy," he continued. "Our customers like the service which a pharmacy offers and we will enhance this with good supply levels, a focused range of OTC products and outstanding consumer offers."

The three are pictured with category buying managers Frank Sutherland (back row left) and Colin Scott.

Alliance Unichem may acquire Dutch wholesaler

Alliance Unichem is set to acquire Interpharm Group, The Netherlands' second-biggest pharmaceutical wholesaler, according to *C&D*'s sources.

The Rotterdam-based group has around 900 employees and reported a turnover of Fl1.5 billion (£405.4 million) in 1998.

One source said the deal had already been completed and would be announced officially in May. Some Interpharm staff, it said, have already been asked to take English lessons.

Interpharm is a subsidiary of Internatio-Muller, whose interests also include technical engineering and distributing speciality chemicals.

AU does not have any direct interests in The Netherlands, but it is involved in a joint study with OPG, the country's largest pharmaceutical wholesaler, to look at the possibilities of setting up a pre-wholesaling network in Europe.

AU and Internatio-Muller refused to comment on the rumours.

XTL float leads way for Israeli biotech firms

XTL Biopharmaceuticals is the first Israeli biotechnology company to seek a listing on the London Stock Exchange with a planned £125m flotation.

Tel Aviv-based XTL, which specialises in drug discovery and development technology, hopes to raise an initial £30m through an institutional placing sponsored by WestLB Panmure.

"The funds raised from flotation will enable us to invest in the company's expansion and to progress our promising pipeline of drugs for infectious and other diseases," said XTL's chief executive officer, Dr Martin Becker.

The company has come up with a new testing method, which it believes could speed up and improve the reliability of drug development. Fifty per cent of compounds are apparently discarded because they prove ineffective on humans but XTL's proprietary Trimera technology allows drug groups to test at an earlier stage, thus saving costs.

Trimera, a process for transforming a normal mouse into an *in vivo* system carrying functional human tissue, can be used to generate human monoclonal antibody drug leads, validate preclinical drug leads in a relevant biological system, optimise lead candidates for further development and discover new therapeutic targets.

Shares in XTL are expected to start trading before the end of April.

● XTL's move coincides with the publication of a survey by business consultancy Ernst & Young, which says the European biotechnology industry is maturing and beginning to deliver on promises. The sector's stock market value rose from £6.5bn to over £11bn in 1999, while revenues rose by 45 per cent and R&D spending by 36 per cent.

However, many companies in the sector remain perilously short of cash, the report says, and a fifth have less than one year's worth of funds in the bank. Senior Ernst & Young consultant Dr Glenn Crocker said the European life sciences industry is currently undergoing evolutionary change as it emerges from a range of harsh financial conditions, with the fittest companies becoming stronger entities.

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BTC to launch credit card with Egg

Boots the Chemists will be launching a combined loyalty and credit card in conjunction with Egg, the financial service company that specialises in internet banking.

From September Advantage card holders will be able to apply for an Advantage credit card, whose key features include:

- more points than the original Advantage loyalty card - purchases in BTC stores earn four points, plus one point extra per pound spent
- one point per pound on all other transactions through the card
- extra one point per pound earned on transactions within the Egg shopping zone
- 10.9 per cent APR for internet users, 14.9 per cent for other users.

Card holders can collect the points they have earned through BTC's Advantage point kiosks. On-line users, meanwhile, can access their monthly statements through Boots' web site.

BTC said the new credit/loyalty card would extend the appeal of its Advantage card and would expand its use to many other types of stores. The extra points it offers will also encourage customers to be loyal to BTC and will attract more shoppers.

Since BTC launched the Advantage card in September 1997, the scheme has notched up 12 million members, of which 8.5 million are said to be regular users. BTC said it was receiving 40,000 new applications a week. Egg has 900,000 customers and around 250,000 are credit card holders.

Record fifth year for Numark

Retail co-operative Numark achieved a fifth successive year of growth in 1999, boosting turnover by 21.2 per cent and operating profit by 51.3 per cent over 1998 figures. The group's rebated allocation for shareholders also increased by 51.4 per cent, to an average of £3,198.

Record year end results show that the number of pharmacies under the Numark umbrella grew from 1,180 to 1,340 during 1999, representing a jump of 14 per cent.

Managing director Terry Norris said the group had taken a number of new programmes on board in the past year, most notably an IT initiative, which "stimulated" shareholders into increasing their support. "We have had remarkable success," he said. "In the third quarter the total rebates exceeded £1m for the first time and in the final quarter we achieved a rebate of £1m from one programme alone."

ADVANCE INFORMATION

May 3, PM Society - Pharmaceutical Question Time and AGM. 'Is the Future Private?' Venue: Reform Club, Pall Mall, London, 6pm-9pm.

May 3, 4 & 5, Vitafoods Exhibition - 09.00 to 17.30, Friday May 5 from 09.00 to 16.00, Exhibition & Conference Centre, Geneva, Switzerland.

May 4, CPP 'Mental health update' (part of College Day), Dunchurch, Nr Rugby.

May 4-5, 'Regulation of dietary supplements in Europe and the USA' at The Berners Hotel, London. For details, tel: 01483 570099.

General Practice '99 is changing its name to **Primary Care 2000**, and is being held at NEC, Birmingham on **May 5-6**. Further details available from Louise Leage, tel: 0151 709 8979.

May 7, Scottish Pharmacists in Mental Health, 25th Annual Seminar at Stirling Management Centre, Stirling University. Application form from Donald Clark, Senior Pharmacist, St John's Hospital, Howden Road West, Livingston EH54 6PP.

May 9, The Society of Cosmetics Scientists is holding a regional lecture at the Compass Inn, Nr Badminton, South Gloucestershire, on 'To pay or not Toupee - Female Hair Loss'. Speaker: Glenn Lyons (Philip Kingsley Trichological Clinic). For further information, tel: 020 8780 1711.

May 9, 'Meeting the requirements of the Computerised systems used in clinical trials guidelines', Washington DC. For details, tel: 020 7404 3040.

The European Society of Clinical Pharmacy's spring conference on Clinical Pharmacy is being held on **May 11-13** in Reykjavik, Iceland. Details from ESCP, tel: +354 554 1400.

May 12, 'Practical aspects of the development of drugs for the treatment of Obesity' at The Rembrand Hotel, London. For details, tel: 01483 570099.

May 12-13, an annual **Parkinson's Disease Multidisciplinary Conference** 'Improving participation in life' at the Posthouse Birmingham City Hotel. For details, tel: 00 44 1273 686889.

Medicines' trade surplus drops 16pc

A 24 per cent increase in medicine imports last year lead to the greatest drop in the UK balance of trade for pharmaceuticals since 1945, according to the Association of the British Pharmaceutical Industry.

While pharmaceutical exports continued to rise, last year's trade surplus of £2,060 million was 16.4 per cent less than in 1998. Exports rose 7 per cent to £6,332m last year, while imports were worth £4,273m.

The ABPI blamed the reduced trade surplus on the strong pound, parallel imports and the erosion of the UK manufacturing base. The positive trade balance in pharmaceuticals, it added, had grown every year since the late 1950s, with only a few exceptions and none of these were as high as the latest drop.

Dr Trevor Jones, ABPI's director-general, said: "The figures confirm the industry's fears that the UK environment for pharmaceuticals is not as encouraging as it has been in the past." The results added impetus to the need for the task force, announced recently, that will make recommendations to the Prime Minister on strengthening the UK's competitiveness in the global environment.

Dr Jones stressed that all was not doom and gloom because pharmaceutical exports were still increasing, and the pharmaceutical industry remained the third biggest earner for Britain in terms of balance of trade.

The industry still leads the world with 15 per cent of sales income reinvested in R&D, compared with the global average of 13.5 per cent, according to a survey by CMR International. UK investment in pharmaceutical R&D is predicted to increase by nearly 14 per cent this year and the survey showed that some international companies have made a tangible commitment to the UK by increasing research staff by over 20 per cent.

Meanwhile, Bill Fullagar, the ABPI's newly elected president, said there would be a further loss of manufacturing jobs if parallel imports – worth an estimated £700-£750m a year – continued at the present rate. Some 7,000 pharmaceutical jobs have been lost over six years.

"I am confident that the action we are taking in conjunction with the Government will be in good time to repair any damage that has been done to international confidence in the UK as a leading place to carry out pharmaceuticals business," he said.

The ABPI's Annual Review 1999 highlights some industry concerns, including decisions made by the National Institute for Clinical Excellence.

Nucare develops training initiative and looks forward to fifth convention

The second in a series of training and development distance learning packs for pharmacy assistants has been released by Nucare.

The six-section pack, 'Hayfever – Symptoms and Treatment', contains case studies, a list of the best OTC treatments currently available and information on how to sell the products. Successful participants gain a Certificate of Course Completion.

Nucare, which has evolved from a buying group into a provider of training and supplier of own-label goods, has also announced details of its fifth Annual Convention, which takes place on 9-11 June in Warwickshire.

Speakers at the Convention, which has the theme 'Managing Change – Meeting the Challenges', include Terry Cater, recently-retired senior vice president of US pharmacy firm McKessons; Marty Belitz, vice president of marketing at Canadian pharmacy chain Shoppers Drug Mart; and Max Goechter and Bruno Steigher, president and managing director, respectively, of Swiss firm TopPharm AG.

The Convention's opening address will be delivered by Tony de Nicola, and Nucare chairman Veni Harania will kick off the first day's sessions.

SmithKline moves to avert investigation

SmithKline Beecham says it is prepared to divest itself of the production of Famvir and Kytril drugs to allay European Commission concerns over competition. Last week the EC delayed a ruling on a proposed merger between the company and fellow pharmaceuticals giant Glaxo Wellcome.

It is hoped that selling the herpes and nausea drugs, which could net up to £600m, will avoid the need for a lengthy investigation by regulators.

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The Estonian capital Tallinn boasts one of the oldest pharmacies in continuous use in the world, with the building dating back to at least 1470. The Old Market Pharmacy, as Felix Corley discovered, follows the best traditions of the Estonian pharmacy profession

Medicines at the old market

Entering the Old Market Pharmacy just below Tallinn's historic market square, you would little guess you are in a shop with such a long pedigree. The counters are new, the shop is bright and spotlessly clean and the medicines are well-presented behind an elegant glass counter.

The building's history can be traced back to 1470 - it is possibly older still - but it has been used as a pharmacy only since 1944, after the Soviet Union invaded the Baltic state of Estonia that had enjoyed just two decades of independence from Moscow. In that year a new shop was set up named, rather prosaically, 'Sanitary Goods Shop No 1'.

The business that exists today can really trace its foundation back to 1969, when the shop was renamed 'Chemist Shop No 210'. The pharmacist, Oie Kotkas, was appointed as manager. In 1986 the shop gained the much more suitable and attractive name 'The Old Market Pharmacy', which it retains to this day.

The Old Market Pharmacy, with graduate Eva Kolatsk (inset)

Drastic changes

Times have changed and the Soviet-style economy has disappeared along with the Soviet Union. Estonia proudly regained its independence in 1991 and set about drastic market reforms that were to transform the economy.

In 1992 the pharmacy became a private company, with Mrs Kotkas as the boss. Under her management and now ownership the business has thrived, meeting the needs of residents, business visitors and tourists.

Among Mrs Kotkas' staff is a young graduate of the pharmacy department of Tallinn's medical school, Eva Kolatsk. She joined the pharmacy after graduating in 1997 and has worked here ever since.

Eva explains that study in higher education is free in Estonia. There are two higher education institutions for pharmacy. As well as the medical school in Tallinn, which offers a three-year pharmacy course, there is also a pharmacy school at the university in Tartu, an historic town in the south.

Students study there for five years and their qualification allows them to do more than those who graduate from the medical school in Tallinn. Those working in the prescription department have to have university-level training, although Tallinn graduates may handle prescriptions on occasion. Mrs Kotkas is a graduate of Tartu University, Eva explains, adding that all pharmacy directors have to have gained university-level pharmacy training. "Tartu is stronger in theory," says Eva. "Practice is stronger in Tallinn than in Tartu."

During her course, Eva worked for one pharmacy in the capital for three weeks in her first year, with a further period of two months in her second year. Before she finished she did a three-month trial period under the supervision of a colleague. And could she go on to do the university course in Tartu if she wanted to? "I could do so, but then I couldn't work in the pharmacy. The course is full-time."

Eva explains the system of prescriptions. "We have a national health system here, although doctors can also practise privately. If you go to a national health service doctor, prescriptions are free. If you go to a private doctor, they cost about 100 kroons [about £4]."

At the pharmacy, customers pay differing amounts towards the cost of the medicine, depending on their status. For children up to the age of 16, pensioners and the sick with certain conditions - such as TB or HIV - medicines are free. In the second category - for example, those with hypertension or high blood pressure - patients have to pay 10 per cent of the cost themselves. For other categories patients have to pay half the cost.

"The doctor marks on the prescription which level of payment the patient has to pay, and the pharmacy checks this off." Eva shows me a file with the lists of the various categories of illnesses and conditions.

While doctors usually specify the medicine to be given, the pharmacist can offer the customer a generic alternative if that is cheaper. "But it is the customer who decides whether to take the named medicine or the generic one."

The pharmacy trade is changing with the times as the volume of products and sales in the area of non-prescription medicines constantly increases. Many of the familiar international brands are on display here at the counter.

"The medicines we sell are made all over the world - in Germany, in France, in Finland and here in Estonia. About a tenth of what we sell is produced here. There is no real difference in price between local and foreign medicines." One local product is Estonian-made ibuprofen. "The biggest local pharmaceutical firm is Tallinna Farmatsia Tehas, which has co-operated with the Danish company Polva."

This is perhaps one of the biggest changes seen in the business over the past decade, when most medicines were from Russia or other countries of the former Soviet Union. "We now get very few medicines from Russia, mainly because of the poor quality."

Pharmacies are allowed to sell a range of other products in addition to medicines, although all must be medical or consumer health products.

Drastic changes

Estonia still has a sizeable Russian minority, mostly made up of industrial workers brought into the country by the Soviet authorities after the War to man the factories. The Old Market Pharmacy - like any other business - must be able to cope with customers who speak either language. As we talk, Eva is interrupted to answer the phone to a Russian-speaking customer.

Finland has always been a close partner of Estonia, even during the Soviet period. Helsinki is two hours from Tallinn by hydrofoil and the Finnish language is close to Estonian.

With the increasing numbers of business people and tourists visiting Estonia, English and German are becoming more useful. "I speak English," says Eva, "while my colleague speaks German. We help each other out." As Estonia opens up to the world, the Old Market Pharmacy is ready for anyone.

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